BEST PRACTICE: The Child Development Project

(CSAP Demonstration Grant #2647)

Description of Best Practice

(Excerpt from "Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

The Child Development Project was a five-year initiative designed as a comprehensive school-based program to reduce risk and bolster protective factors related to substance use. The program was implemented at 12 demonstration schools in six school districts located throughout the United States (six on the West Coast, two each in the South, the Southeast and the Northeast.) Youth populations targeted at each school also varied widely, ranging from 2% to 95% receiving free or reduced lunch, 26% to 100% being members of minority groups, and having achievement test scores ranging from the 24th to the 67th percentile.

The effort attempted to transform the school into a "Community of Caring", in which a student's intrinsic motivation to learn was nurtured, and supportive social relationships, sense of common purpose, and a commitment to pro-social values responsive to children's developmental needs were commonplace. The specific intervention activities cited to accomplish these objectives included: cooperative classroom learning; implementing "values rich" literature-based reading and language arts programs; establishing a developmental discipline program and classroom management plan with input from the students vis-a-vis appropriate behavioral contingencies; developing classroom and school-community building projects that fostered cooperation and communication between teachers, students and families; and homeside activities in which youth and families work together to develop classroom presentations, etc.

The basic mode of implementation was that of trainers training trainers. Initially a small cadre of supervisory staff and teachers were trained by project and school district staff in the spring of 1992. They returned to their schools and trained staff there. Trained school staff provided most direct services including effecting cooperative classroom learning efforts, modifying curricula, as well as designing and implementing the discipline policies.

Risk Factors Addressed

Low commitment to school

Protective Factors Addressed

Bonding: School

CSAP Strategy

Information dissemination
Education
Community-based process
Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Elementary school
- Multi-ethnic
- Multi income levels

Evaluating This Best Practice

This best practice comes, upon request, with an evaluation tool that can be used when implementing this strategy. There is no cost for the tool.

Note: An extensive student questionnaire (grades 3-6) and teacher questionnaire was developed for research use. This is a costly measure to administer and analyze. Data analysis service is not provided.

The following are suggested areas to assess when implementing this practice:

- Assess degree that students like school and their learning motivation
- Assess improvements in teacher practices leading to positive changes in classroom behaviors

Research Conclusions

Excerpt from "Understanding Substance Abuse Prevention — Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished document.)

Findings provide considerable support for CDP's underlying conceptual model, as well as evidence that CDP training had a statistically significant, moderate effect on classroom practices which, in turn, increased students' sense of community and had positive effects on a number of student outcome variables.

In summary, researchers found data patterns expected from their theoretical orientation supporting the implementation model's effectiveness. Further, treatment-comparison and internal contrasts, using fidelity of implementation as a means to partition schools demonstrated clearly that when implemented more fully, program effects increased in the areas of skills, behaviors, school achievement and bonding, and substance use.

Costs as of May 2001 (Subject to Change)

Training Time: Three days (18 hrs)

Training Costs:
$6,000 which can be shared by up to five school teams

Note: This is a training of trainers approach. A team of four to six participants from a school receives a three-day institute training and then provides staff development to a school staff.

Strategy Implementation:

- $450 per school for the collegial study package which includes videos and tools for the follow up training and program implementation in each school
- $50 per teacher for materials and books

Special Considerations

Please consider the following before selecting this strategy for your community:

- Classroom teachers attend approximately 10 hours of staff development from the school team and participate in 10 hours of collegial study throughout the year.
- Schools must be prepared to provide on-going staff development support to teachers in program implementation and to purchase classroom materials.

Contact Information

For more information on this program, visit web sites:
http://modelprograms.samhsa.gov
http://www.devstu.org

For training information contact:
Stefan Dasho
Phone: 510.533.0213 x 270 or
800.666.7270

For professional development services, curriculum, and teacher resource materials information contact:
Denise Wood, Information Coordinator
Developmental Studies Center
2000 Embarcadero, Suite 305
Oakland, CA 94606-5300
E-mail: info@devstu.org
Phone: 510.533.0213 x 239 or
800.666.7270
Fax: 510.464.3670

To order materials, contact:
E-mail: pubs@devstu.org
Phone: 510.533.0213 x 281

BEST PRACTICE: Communities Mobilizing for Change on Alcohol

Description of Best Practice

(Excerpt from *Alcohol Epidemiology Program*, University of Minnesota)

CMCA is a community organizing effort designed to change policies and practices of major community institutions in ways that reduce access to alcohol by teenagers. CMCA was developed and evaluated in a 15-community randomized trial by the Alcohol Epidemiology Program at the University of Minnesota School of Public Health, under the direction of Professor Alexander C. Wagenaar.

The intervention approach involves activating the citizenry of communities to achieve changes in local public policies and changes in the practices of major community institutions, such as law enforcement, licensing departments, community events, civic groups, churches and synagogues, schools, and local mass media. The objective is to reduce the flow of alcohol to youth from illegal sales by retail establishments, and from provision of alcohol to youth by other adults in the community.

(Excerpt from *Journal of Community Psychology*, Vol. 27, No. 3, 315-326 (1999) © 1999 John Wiley & Sons, Inc.)

CMCA used a community organizing approach to implement changes in local institutional policies. Institutional change included both formalized behavior, such as new ordinances and written policies, and informal practices such as more frequent patrolling by local police agencies or increased media coverage of alcohol-related issues. Organized citizens in each of the seven CMCA intervention communities identified and promoted a variety of policy initiatives designed to change the local environment in a way that made it more difficult for young people to obtain alcohol, and made underage drinking less acceptable within the local culture.

Part-time local organizers in each intervention community followed an organizing process that included seven stages:

1) Assessing the community — assessing community wants, needs and resources.
2) Creating a core leadership group — identifying key supporters to plan and implement the organizing campaign.
3) Developing a plan of action — creating a workplan and timeline for implementing activities and accomplishing goals.
4) Building a mass base of support — attracting new supporters and building community awareness and involvement in the campaign.
5) Implementing the action plan — implementing activities identified by the campaign leadership that were designed to achieve the goals.
6) Maintaining the organization and institutionalizing change — initiating activities to sustain the campaign and its accomplishments.
7) Evaluating changes — evaluating campaign activities and outcomes.

Risk Factors Addressed

Community laws and norms favorable toward alcohol use
Availability of alcohol

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- 18- to 20-year-olds
- On- and off-sale alcohol retail merchants

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess 18- to 20-year-olds' alcohol consumption, attitudes and compliance with policies
- Assess merchant compliance in off-sale and on-sale outlets, with alcohol policies and restrictions.

Research Conclusions

(Excerpt from *http://modelprograms.samhsa.gov*)

CMCA was evaluated in a fully randomized trial across 15 communities. Data collection included pre and post in-school surveys of 12th graders, telephone surveys of 18- to 20-year-olds and alcohol merchants, direct testing of the propensity of alcohol retailers to sell to young buyers, and monitoring changes in relevant practices of community institutions.

Results show that:

- CMCA significantly and favorably affected the behavior of 18- to 20-year-olds and the alcohol sales practices of bars and restaurants
- Alcohol retailers increased age-identification checking and reduced sales to minors, and 18- to 20-year-olds were less likely to try to purchase alcohol, less likely to frequent bars, less likely to drink and, importantly, less likely to provide alcohol to other teens.
- Arrests for driving under the influence of alcohol also declined significantly among 18- to 20-year-olds. Younger adolescents were not significantly affected by CMCA.

Costs and Special Considerations

Not available

Contact Information

For more information on this program, visit web site:
http://modelprograms.samhsa.gov

No technical assistance, training, or manuals are available for this strategy. Several papers were written documenting the CMCA project. To obtain citations for and to order all of the papers, visit web site:
www.epi.umn.edu/alcohol

These papers can assist you in replicating the strategy. The following can also be found on their web site: alcohol compliance checks procedures manual, model ordinances, model public policies, model institutional policies, and reprints of papers.

For questions regarding the research papers, contact:
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Division of Epidemiology School of Public Health
1300 South 2nd Street, Suite 300
Minneapolis, MN 55454-1015
E-mail: wagenaar@epi.umn.edu
Phone: 612.624.8370
Fax: 612.624.0315

BEST PRACTICE: Communities That Care

Description of Best Practice

(Excerpt from materials provided by Channing Bete in December 2001.)

The Communities That Care (CTC) process is an operating system that provides research-based tools to help communities mobilize to promote the positive development of children and youth and to prevent adolescent problem behaviors that impede positive development including substance abuse, delinquency, teen pregnancy, school dropout, and violence.

The CTC process was developed by David Hawkins, Ph.D., and Richard Catalano, Ph.D., to help communities plan, implement, and evaluate proven-effective prevention programs to meet their particular needs. These programs can address some or all focus areas – family, school, community-based youth, and community. The full CTC process is based on the public health model and includes five phases. (Alternative CTC programs can be customized to fit specific community needs.)

Phase I: Getting Started — Create preliminary organization and identify community readiness issues.

Phase II: Getting Organized — Engage key leaders, educate and involve the community, and address readiness issues.

Phase III: Developing a Community Profile — Collect data; analyze and prioritize community risk and protective factors. Conduct a resource assessment.

Phase IV: Creating a Comprehensive Youth Development Plan — Identify strategies to address community priorities, matching proven-effective programs to specific community needs.

Phase V: Implementing and Evaluating Programs — Implement programs, conduct evaluations and refine strategies.

The Communities That Care operating system helps communities to:

- Mobilize and engage diverse members of the community in positive youth development.
- Target scarce resources to most effective use for positive youth results.
- Implement a clear decision-making process for allocating funding and other resources.
- Establish a shared vision, common language and collaborative prevention planning structure.
- Develop a data-driven profile of community strengths and challenges.
- Establish action priorities based on the data showing community needs.
- Develop clear and measurable outcomes that can be tracked over time to show progress.

Risk Factors Addressed

Low neighborhood attachment and community disorganization

Community laws and norms favorable toward drug use, firearms and crime

Transitions and mobility

Protective Factors Addressed

Healthy beliefs and clear standards
Bonding: Opportunities, skills and recognition

CSAP Strategy

Community-based process

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Not specified

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The evaluation tool is a youth survey that can be done prior to training and implementation of programs and then 1-2 years following.

Evaluation Tool Cost:
$1.80 per student survey plus $700 report charge per county and / or $500 report charge per individual school

The following suggestion is an area you may want to assess if you implement this best practice:

- Assess the community coalition's progress in conducting an assessment of risk and protective factors in their community and in implementing strategies to reduce prevalent risk and protective factors.

Research Conclusions

(Excerpt from *Communities That Care Prevention Strategies: A Research Guide to What Works, Developmental Research and Programs*, 1996, pp. 89-90 and materials from Channing Bete Company.)

The following research relates to the effectiveness of the Communities That Care in helping communities to mobilize for prevention needs assessment; and prevention program planning, implementation, and evaluation:

Results from the TOGETHER! project show that multiple communities can be mobilized using the Communities That Care strategy and that, with sufficient training, community prevention boards are both willing and able to conduct assessments of risk and protective factors in their community and implement promising risk reduction strategies.

Of the 40 Oregon communities that initially responded to the invitation to participate in the project, thirty-five com-

pleted all three of the Communities That Care trainings. Within a year after training, twenty-eight boards had completed risk-focused prevention plans and less than a year into the planning and implementation phase, 27 had begun implementing risk reduction strategies. Four years later, 31 boards were still active, and 28 of them were implementing risk reduction programs (Harachi et al., 1995).

A comparison of the Communities That Care (CTC) strategy used in the TOGETHER! project and the Washington State Community Youth Activity Program (CYAP) showed that CTC was more effective in mobilizing communities for the design and implementation of risk reduction strategies. Although both projects were successful in mobilizing community boards to plan and implement prevention activities, the Communities That Care process was more successful than the CYAP project at promoting planning and program activities aimed at specific, empirically-based risk factors identified through a community risk assessment process (Arthur et al., 1994).

Costs as of December 2001 (Subject to Change)

Training Costs/Time:
$3,400 for 80 participants for a one-half day Key Leader Orientation

$5,500 for 40 participants for two days of Community Board Orientation

$3,400 for 40 participants for a one-day Community Assessment Training

$3,400 for 40 participants for a one-day Community Resources and Strengths Training

$8,000 for 40 participants for two days of Community Planning Training

Special Considerations

None specified by program developers

Contact Information

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E-mail: mcody@channing-bete.com
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Web site: *http://www.channing-bete.com*

BEST PRACTICE: Counter-Advertising (Tobacco Specific)

Description of Best Practice

(Excerpt from: *Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners*, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 10-12.)

The primary goal of counter-advertising is to change perceived norms among children and adolescents regarding tobacco use. Research and experience demonstrate that adolescents develop attitudes, beliefs, and behaviors regarding tobacco use from peers, family members, television, and other cultural sources. Adolescents often think that tobacco use is more widespread and universally acceptable than it actually is. Advertising links tobacco use with peer acceptance, success, and good times. Media messages that promote negative images about tobacco use, reveal the number of teens who actually use tobacco, and address the unacceptableness of tobacco use should help change these perceived norms.

Activities:

- Radio and television campaigns
- Multilevel media campaigns that include billboards, posters, magazines, radio, and television
- A mass-media campaign linked to a school-based prevention intervention
- Airing of anti-tobacco media campaigns on prime-time television

Risk Factors Addressed

Community laws and norms favorable toward drug use
Favorable attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

No specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess increase of exposure of children and adolescents to negative messages about using tobacco
- Assess increase of positive messages about not using tobacco
- Assess increase in adolescents' ability to identify hidden messages in tobacco advertising
- Assess increase in adolescents' awareness of tobacco industry marketing tactics

Research Conclusions

(Excerpt from: *Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners*, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1, pp. 10-12.)

The research evidence reviewed indicates that it is possible to implement counter-advertising interventions: There is strong evidence that counter-advertising is effective in changing the attitudes of adolescents about tobacco use. There is medium evidence that counter-advertising is effective in reducing adolescent tobacco use.

Lessons Learned From Reviewed Evidence

- Counter-advertising, in the form of multi-component media-based prevention efforts, can have an effect on youth with regard to awareness of media campaigns, decreased smoking prevalence, and nonsmokers' decreased intention to start. These efforts demonstrate the ability to result in increased negative attitudes toward smoking, increased understanding of the consequences of smoking, and decreased rates of friends' approval of smoking.
- Multi-component prevention efforts are more effective than single-component prevention programs. Media campaigns have been shown to support and promote other components and vice versa. Effective media campaigns involve linkages with other intervention activities.
- To be effective, media messages should be age appropriate and designed with the target audience's developmental stage in mind. In particular, messages should not be too subtle or too sophisticated.

Costs and Special Considerations

None identified

Contact Information

For more information on this best practice: order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at:

Phone: 800.729.6686, or

Web site: *http://ncadi.samhsa.gov*

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols Systems Series 1: publication order no. "PHD 744" (for 12-page community guide) "PHD 745" (for prevention practitioner's guide) and "PHD 746" (full document).

BEST PRACTICE: Creating Lasting Connections

(CSAP Demonstration Grant #1279)

Description of Best Practice

(Excerpt from "Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished.)

Creating Lasting Connections (CLC) was designed to: work with both community and family systems to identify youth and parents / guardians at high-risk for AOD (alcohol / other drug) use, increase familial resilience to and decrease risk for AOD use, provide / refer families in need to appropriate social service agencies, and to mobilize communities to prevent AOD use.

Because churches already foster natural support systems, they were identified as the pivotal community agency from which to implement this culturally competent / appropriate early intervention program for high-risk youth age 11-15 and their families.

Subsequent to being selected, church communities developed Church Advocate Teams (CAT) composed of 5-10 church staff and nominated community members. CAT staff underwent an average of 20 hours of training over seven sessions, after which they were tasked with performing outreach activities, identifying and recruiting high-risk one hundred 15-year-olds and their families, scheduling and performing family training, preparing and implementing field data collection, and preparing linkages for successful self-referrals with various human service providers.

Initially, parents / guardians and teens met in separate sessions before meeting as intact families in the final sessions. Participating parents / guardians received about 55 hours of training on AOD issues (20 hours) parenting skills (20 hours) and communication skills (15 hours)

Youth received about 15 hours of training concerning AOD issues, communication skills, and refusal skills.

Families requiring AOD intervention or other social services were referred to appropriate agencies by the CAT leader or case manager. CAT members and / or the staff case manager performed telephone and / or in-house follow-ups with participating families for one year subsequent to their participation in CLC.

Note: Although the original research for Creating Lasting Connections was conducted in churches, this program is both community and school-based by design.

Risk Factors Addressed

Family conflict
Family management problems
Parental attitudes and involvement
Early first use

Protective Factors Addressed

Bonding: Family
Skills: Social competence

CSAP Strategy

Information dissemination
Education
Problem identification and referral
Community-based process

Type of Strategy

Selective

Populations Appropriate for This Best Practice

11- to 15-year-old youth and their parents / guardians

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
$300. This cost covers:

- Self-administered surveys for both youth and parents
- The psychometric properties of the scales in the surveys
- Survey administration and scoring guidelines
- Parent consent forms
- Contact information for technical assistance on evaluating CLFC
- Permission to copy surveys for evaluating the CLFC Program (only CLFC)

The following are suggested areas to assess when implementing this practice:

- Determine whether family management skills were enhanced
- Determine improved bonding with mother, father, and siblings
- Determine if more honest communication between family members exists
- Determine if the onset of AOD use was delayed overall

Research Conclusions

(Excerpt from "Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs," Center for Substance Abuse Prevention, unpublished.)

Results from this study are complex, deriving from a total of 10 experimental sites assessed over 5 years. Still, data indicate that the intervention was effective in increasing a number of resiliency factors, and that these improvements were related to AOD use.

Overall, these data indicate that as the intervention improved family function and community empowerment, parental and youth substance use decreased.

Costs as of May 2001 (Subject to Change)

Training Time: 40 - 80 hours

Training Costs:
$750 per participant (for each of one or two weeks of training in Louisville) OR $200 to $1,200 per day (depending on the number of trainers and their level of experience) plus travel, lodging and expenses for on-site training.

Note: Training is strongly recommended, although training and technical assistance are not required. Please see further training comment in "Special Considerations."

Strategy Implementation:
Approximately $17,500 for 40 families (approximately 50 youth and 40 parents)

Note: This program has three separate adult modules and three separate youth modules. Implementation cost is difficult to predetermine because the program has a variety of implementation choices creating correlating fluctuations in costs. It is foreseeable that costs could range anywhere from minimally $1,500 to $250,000 when serving 100 families per year. For agencies serious about program implementation as designed, the typical first-year budget is $25,000 and up, while costs in subsequent years drop considerably.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Agencies interested in implementing the CLFC curriculum are encouraged to complete a readiness assessment survey designed for COPE's staff to determine the appropriate level of training needed. (Most agencies find one-week of training sufficient.)
- In addition, custom trainings are provided for groups on-site, lasting between three and nine days.
- COPE offers a list of influential and effective trainer characteristics, including: outgoing; caring; non-judgmental; able to recognize, name and express other feelings as they occur; and other characteristics.
- Although the original research for Creating Lasting Connections was conducted in churches, this program is both community and school-based by design.

Contact Information

For more information on this program, visit web sites:
http://modelprograms.samhsa.gov and
http://www.copes.org

For training, technical assistance, materials and additional program information, contact:

Ted N. Strader, M.S.
Council on Prevention Education: Substances, Inc.
845 Barret Avenue
Louisville, KY 40204

E-mail: tstrader@sprynet.com

Phone: 502.583.6820

Fax: 502.583.6832

Teresa Boyd can also be contacted at the above numbers for more information about the program.

BEST PRACTICE: DARE to Be You

(CSAP Demonstration Grant #1397)

Description of Best Practice

(Excerpt from materials provided by DARE To Be You staff in December 2001.)

DARE To Be You (DTBY) is a multilevel, primary prevention program for children 2 to 5 years old and their families. It significantly lowers the risk of future substance abuse and other high-risk activities by dramatically improving parent and child resiliency factors in the areas of communication, problem solving, self-esteem, and family skills. Program interventions are designed to:

- Improve parents' sense of competence and satisfaction with being a parent
- Provide parents with knowledge and understanding of appropriate child management strategies
- Improve parents' and children's relationships with their families and peers
- Boost children's developmental levels

The DARE To Be You program should have a site sponsor—a key agency that works with families. While the site sponsor may vary with the needs of the community, it must be respected by the community. Sponsors may be Head Start or other preschool educational programs, schools, family centers or coalition groups. The program is delivered to families at a site convenient to the families in a location comfortable for families to attend. The program consists of three components including a:

- Family Component, which offers parent, youth, and family training and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decision-making skills. It consists of an initial 12-week family workshop series (30 hours) and semiannual, 12-hour reinforcing family workshops. (After-DARE support groups are also recommended.)
- School Component, which trains and supports teachers and child care providers who work with the target youth.
- Community Component, which trains community members who interact with target families, health department, social services, family center personnel, probation, and counselors.

Both School and Community Component participants have the same 15-hour training requirement. Training for childcare providers and involved community members will also be held at a placed deemed appropriate by the site sponsor.

DARE To Be You program materials are available in English and Spanish.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Skills: Problem-solving and communication
Bonding: Family

CSAP Strategy

Education

Type of Strategy

Universal
Selective

Populations Appropriate for This Best Practice

- Two- to five-year-old children and their parents
- Native American
- Hispanic/Latino
- Caucasian
- Urban, Rural, Suburban

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. The program's instrument was a compilation of instruments "owned" by other authors. An evaluation protocol is provided describing the instruments and costs. *Evaluation Protocol Handbook*
Cost: $3.00

The following suggestion is an area you may want to assess if you implement this best practice:

- Assess whether family management skills were enhanced, including appropriate control techniques.

Research Conclusions

(Excerpt from materials provided by DARE To Be You staff in December 2001.)

Participants of DARE To Be You showed:

- Increased parental effectiveness and satisfaction, maintained over two years*
- Increased appropriate parental limit setting, maintained for two years
- Decreased parental child blaming and harsh punishment
- Increased child developmental level, maintained for at least two years*

Outcomes include:

- 95% of the families completed the intervention with at least 20 hours
- 80% of the families completed with more than one adult family member
- 45% of the families had a male father figure participate and complete the intervention

*Compared to control group

- Satisfaction with support systems and self-sufficiency increased significantly
- Families report children better self-managed and better family communication

Costs as of December 2001 (Subject to Change)

Training Time: 20 - 24 hours

Training Cost:
$4,200 for a 20-hour training plus travel and per diem expenses for trainer. This included a set of seven manuals, one activity book, and postage.

Note: Up to 35 people can be trained. The training is designed with community needs in mind, e.g., implementers only, or implementers and community / agency collaborators. Materials (books and kits) are extra and selected according to community need.

For additional cost information, please contact DARE To Be You.

Special Considerations

Please call the contact below.

Contact Information

For more information on this program, visit web site:
http://modelprograms.samhsa.gov

For training, technical assistance, and materials contact:
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E-mail: darecort@coop.ext.colostate.edu

Phone: 970.565.3606

Fax: 970.565.4641

BEST PRACTICE: Economic Interventions (Increasing Taxes)

Description of Best Practice

(Excerpts from R*educing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners*, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp. 9-10 and from *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism, October 1996, No. 34, PH 370.)

The primary goals of economic interventions as a prevention approach are to raise the price of tobacco and alcohol products through increased taxes and thereby prevent youth from taking up smoking and drinking, delay the age at which they might begin, and decrease the level of consumption.

Activities include an increase in taxes on cigarettes and alcohol through state legislation, and an increase in taxes on cigarettes and alcohol through the federal legislative process.

Risk Factors Addressed

Availability of drugs
Community laws and norms

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Studies not done with specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the number and type of policies that related to the taxation of alcohol and tobacco
- Assess decrease in alcohol and tobacco use by youth

Research Conclusions

Of the studies reviewed and summarized in *Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners* (see below), there is "strong" evidence that instituting tobacco tax increases is an effective approach to reduce the prevalence of adolescent tobacco use — especially when the tax is sufficiently high and is linked to the consumer price index. NIAAA's *Alcohol Alert* cited research that found that alcohol taxes and prices affect alcohol consumption and associated consequences.

Contact Information

For information on how to increase alcohol taxes in your state / community, obtain a copy of *State Alcohol Taxes & Health: A Citizen's Action Guide from Center for Science in the Public Interest.* Portions of the publication are available on our web site:

http://www.cspinet.org/booze/taxguide/tax_toc.htm

or obtain a copy from:

1875 Connecticut Avenue NW, Suite 300
Washington D.C. 20009-5728

Phone: 202.332.9110, x 385

The cost is $10 plus shipping and handling.

Note: For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI).

Phone: 800.729.6686, or

Web site: *http://ncadi.samhsa.gov*

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, publication order no. "PHD 745" (for prevention practitioners guide) and "PHD 746" (full document).

To obtain a copy of *Alcohol Alert*, National Institute on Alcohol Abuse and Alcoholism (NIAAA) No. 34, PH 370, October 1996, view the full text at the web site:

http://www.niaaa.nih.gov

or contact NIAAA at:

Phone: 301.443.3860

BEST PRACTICE: (CICC's) Effective Black Parenting Program

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention,* Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 34-35.)

Program Origin
This program was developed by the Center for the Improvement of Child Caring (CICC) in response to the criticism in the late 1970's that none of the widely used parent training programs in the U.S. were created specifically for African American Parents. In 1985, the Effective Black Parenting Program was developed that integrated all of the research findings and field test results.

Program Objectives
This cognitive-behavioral program is designed to foster effective family communication, healthy African American identity, extended family values, child growth and development, and healthy self-esteem. It is designed to facilitate community efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances.

Program Strategies
Effective African American Parenting is based on a pro-social achievement orientation to African American parenting and recognizes the special street pressures in inner city African American communities that make it difficult for African American parents to maintain such an orientation.

Two major parenting strategies are presented, The Family Approach for Developing Respectful Behaviors (utilizing family rules and family rule guidelines) and the Thinking Parent's Approach to Disrespectful Child Behaviors (utilizing systematic decision making processes).

The program teaches rule development, family meeting and problem assessment skills, and shares basic child development information to help parents make age appropriate rules, and several basic child management skills: effective praise, mild social disapproval, systematic ignoring, time out, and special incentives.

The regular program consists of 14 three-hour training sessions and a fifteenth session for a graduation ceremony. Each training session includes an extensive review and role playing of ideas and skills which were taught in previous sessions. Optimal group size appears to be about 15 to 20 parents, but more could be accommodated if necessary. A one-day seminar version of the program can be conducted for 50 to 500 parents.

Resources Needed and Materials Available
Materials include an instructor's manual, instructional charts, a parent's notebook, a promotional video, promotional flyers, and graduation certificates. Three supplementary books are available.

Special Characteristics
This program includes discussion of traditional African American discipline and contrasts this with modern African American discipline strategies in teaching parents new skills. Issues relevant to African American pride and ways of coping with racism are addressed. Child abuse information is included in a discussion of the disadvantages of using corporal punishment as a disciplinary technique.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family, Community

CSAP Strategy

Information dissemination
Education
Type of Strategy
Universal

Populations Appropriate for This Best Practice

African American parents of children two- to 12-years-old

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. There is no cost for the tool.

The following is a suggestion of an area you may want to assess if you implement this best practice:

- Assess the increase in family management skills

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention,* Office of Juvenile Justice and Delinquency Prevention, 1993, p. 35.)

Field test results indicate that:

- The program in its fully integrated form has direct and positive effects on many of the family and child risk factors that have been found through research to put children at risk for drug abuse, delinquency, and other social and health problems
- It reduces negative family communication
- Enhances parental involvement with children
- Reduces child behavior problems
- Enhances limit-setting
- Improves the general psychological well-being of parents

Costs as of December 2001 (Subject to Change)

Training Time: Five full days of intensive training

Training Cost: $925 per participant.

Note: Enrollment fee includes the cost of the Instructor's Kit ($413). Workshops are led by professionals who are African American.

Strategy Implementation:
$23 per participant for the Parent Handbook

Special Considerations

Please consider the following before selecting this strategy for your community:

- It is important for instructors to receive training before starting to implement the program.
- Utilize multi-media strategies for recruiting parents — the traditional media, organizations that parents are related to, and one-on-one requests for participation.
- Use many participation incentives, including refundable reservation or enrollment fees, free items earned as a result of regular attendance, etc.

Contact Information

For more information visit web site:
http://www.ciccparenting.org

For additional information on training, technical assistance, and materials contact:
Norma Paniagua
Phone: 818.980.0903

For additional program information contact:
Kerby T. Alvy, Ph.D.
Center for the Improvement of Child Caring
11331 Ventura Blvd., Suite 103
Studio City, CA 91604
E-mail: kalvy@aol.com
Phone: 818.980.0903
Fax: 818.753.1054

BEST PRACTICE: Families and Schools Together

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 49-50.)

Program Objectives
The FAST program is designed to:

(1) Enhance family functioning by strengthening the parent-child relationship in specific ways and empowering the parents to become primary prevention agents for their own children.

(2) Prevent the target child from experiencing school failure by improving the child's behavior and performance, empowering parents as partners in the education process, and increasing family feelings of affiliation with their schools.

(3) Prevent substance abuse by the child and the family members by increasing knowledge and awareness of substance abuse and its impact on child development, and linking the family to assessment and treatment services if necessary.

(4) Reduce the everyday stress that parents and children experience by developing an ongoing support group for parents of at-risk students, linking participants to needed resources, and building the self-esteem of each family member.

Program Strategies
FAST uses a collaborative, whole family approach to achieve its goals. An eight-week curriculum for the Elementary School program (10-week for Early Childhood, 14-week for Middle School Program) of multiple-family group activities, followed by ongoing monthly meetings, incorporates the following activities: a meal hosted by a family, a family singalong, structured family communication exercises, family feelings identification exercises, parent support meetings while children play, one-to-one quality time, winning-as-a-family-unit exercises, a closing ritual, a substance abuse education component, graduation, and development of a school-based parent advisory council of FAST program graduates.

Recruitment and Retention
FAST identifies participants through a strong and active recruitment process in which school personnel identify at-risk children. Other recruitment activities include home visits and training in recruitment, plus a positive non-stigmatizing programmatic approach that focuses on strengths and empowerment incentives, and removal of obstacles to participation through provision of transportation and childcare. Of families initially telephoned by schools, 63 percent agreed to attend at least one meeting. Eighty-two percent of families that attend at least one meeting graduate from the FAST program. Recruitment and retention rates reflect first-time implementation at new sites; rates at ongoing sites are typically substantially higher.

Staffing
FAST is a collaborative effort between a school, a mental health agency, an alcohol and other drug abuse prevention specialist, and parents. Multifamily group meetings are staffed by a school staff member such as a social worker, counselor, psychologist or principle; a parent, liaison worker, or FAST facilitator; an alcohol and other drug abuse prevention specialist; and a mental health professional. Volunteers are recruited and trained to help at meetings.

Resources Needed and Materials Available
Necessary resources include a large room and materials to execute family activities. The FAST Program Manual describes all the resources needed to initiate the program. Please contact FAST for information on program planning, implementation, budgets, team training, and certification.

Special Characteristics
FAST targets whole families, reaches "unreachable" families, and uses a truly collaborative approach. FAST breaks down barriers to trust and stereotypes and promotes development of active parent groups and advocacy councils. FAST utilizes a stress / social-support model that builds on family strengths. FAST is explicit about program values. The FAST program model and activities are strongly grounded in an empirical research base.

Comments on Implementation/Replication
FAST has been successfully replicated in 39 states and five countries with rural, medium-sized, and urban communities. FAST groups have been made up of culturally diverse families, as well as solely Spanish-speaking people, Native Americans, African Americans, Asian Americans, or European Americans. FAST has developed a thorough and highly effective training model that includes links between communities and onsite training of collaborative teams.

Risk Factors Addressed

Family management problems
Parental attitudes and involvement
Low commitment to school

Protective Factors Addressed

Bonding: Family and School

CSAP Strategy

Information dissemination
Education
Problem identification and referral

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Preschool, elementary, and middle-school aged children whom teachers have identified as at risk for later problems and their families

- Infants and toddlers
- African American
- Native American
- Caucasian
- Hispanic / Latino
- Rural, medium-sized, and urban communities

Evaluating This Best Practice

This best practice uses evaluation tools that are processed to create a final report.

Final Evaluation Report Cost:
$1,000 per cycle. Evaluation process includes use of questionnaires, data entry, processing, final evaluation report.

The following are suggested areas to assess when implementing this practice:

- Assess improvements in child behavior problems
- Assess improvements in family cohesion
- Assess increases in involvement of parents with their children's schools
- Assess improvements in family management skills

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1003, p. 50.)

Scores on objective, standardized assessment instruments demonstrate significant:

- Pre- to post-program improvements in child behavior problems, as rated by both parents and teachers
- Improvements in family cohesion
- Decreases in social isolation of parents
- Increases in involvement of parents with their children's schools.

Collaborative teams rate the program as very successful. Data have been collected on over 700 elementary school children, and continuing evaluations of program effectiveness are in progress.

Costs as of December 2001 (subject to change)

Training Time: Approximately 25 hours

Training Costs: Approximately $9,000

Note: This cost pertains to elementary program training fees. It includes program manuals for team members, phase 1 training box with all paper materials needed for team training, final evaluation report, and certified FAST Trainer for five site visits. (You will also need to budget for trainer's travel cost / lodging / meals / per diem.)

Strategy Implementation:
$2,500 per family, averaging 10 families per session

Special Considerations

Please consider the following before selecting this strategy for your community:

- A packet of information is available addressing considerations for implementing the FAST program, including such issues as how to set up teams and how to find a location. The packet can be ordered by calling toll free 888.629.2481.

Contact Information

Pat Davenport, Executive Director
FAST National Training and Evaluation Center
P.O. Box 14500
Madison, WI 53704

E-mail: fast@chorus.net
Phone: 608.663.2382 or
888.629.2481
Fax: 608.663.2336
Web site: *http://www.wcer.wisc.edu/FAST*

BEST PRACTICE: Family Advocacy Network

(FAN CLUB) (CSAP Demonstration Grant #1383)

Description of Best Practice

(Excerpt from *Understanding Substance Abuse Prevention — Toward the 21st Century: A Primer on Effective Programs,* Center for Substance Abuse Prevention, unpublished document.)

In conjunction with the SMART Moves three-year youth drug prevention program [see description below], a parent involvement program called the Family Advocacy Network (FAN Club) was implemented for parents of prevention program youth at the four Boys & Girls Clubs serving as demonstration sites. The goal of the FAN Club was to strengthen families in the program by creating a bond between youth and their parents, reducing maternal isolation, providing opportunities for families to participate in pleasurable activities together, helping parents influence their children to lead drug-free lives, and providing social and instrumental support for families.

The FAN Club was designed to focus on families' strengths rather than deficits, to inspire parental confidence and competence, to respond to family cultural preferences and values, to recognize the developmental needs of parents, to be flexible and responsive to parental needs, to encourage voluntary participation by parents, and to include parents as partners in the planning and implementation of the program.

The three-year youth drug prevention program [mentioned above] consisted of the Start SMART and Stay SMART programs, components of Boys & Girls Clubs of America's National Prevention Program (SMART Moves), and SMART Leaders, developed by the investigators. These sequential programs were found effective in a previous CSAP grant. (See SMART Moves.)

Start SMART (10 sessions; 1-1/2 hours) Stay SMART (12 sessions; 1-1/2 hours) and SMART Leaders (5 sessions; 1-1/2 hours) are curriculum-based programs that use role playing, group activities, and discussion to promote social skills, including peer resistance skills, problem solving/decision-making skills, conservative group norms regarding substance use, and knowledge of the health consequences and prevalence of alcohol, tobacco, and other drug (ATOD) use by youth and adults. To continue in the three-year sequential program, youth were required to participate in 75% of the sessions in each program. Each year, when structured prevention program sessions were not taking place, program youth participated in monthly activities designed to stress nondrug use norms and to keep the youth involved in the prevention program.

Risk Factors Addressed

Favorable attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards
Skills: Social competence
Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- 11 to 15 years old and families
- African American
- Hispanic
- Caucasian

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess perceived benefits from using marijuana
- Assess ability to refuse alcohol, tobacco, and marijuana

Research Conclusions

(Excerpt from *Understanding Substance Abuse Prevention – Toward the 21st Century: A Primer on Effective Programs,* Center for Substance Abuse Prevention, unpublished document.)

Results from the youth self-report questionnaire indicated positive program effects for youth in Boys & Girls Clubs that offered the three-year youth prevention program with monthly youth activities and the FAN Club parent program (FAN Club group). Over the three years, the FAN Club group reported increasing ability to refuse alcohol, marijuana, and cigarettes, and increasing negative attitudes toward marijuana use.

Costs and Special Considerations

Please inquire of the contact below

Contact Information:

For more information on this program, visit web site:
http://modelprograms.samhsa.gov

For materials, contact Supply Services at:
Phone: 404.487.5701

For training and technical assistance, contact CSAP at :
Phone: 877.773.8546

Mylo Carbia
Boys & Girls Clubs of America
1230 W Peachtree St. NW
Atlanta, GA 30309-3447

E-mail: mcpuig@bgca.org

Phone: 404.487.5766

Fax: 404.487.5789

Web site: *http://www.bgca.org*

BEST PRACTICE: Family Effectiveness Training

Description of Best Practice

(Excerpts from materials provided by the Center for Family Studies, University of Miami.)

The University of Miami, School of Medicine, Department of Psychiatric and Behavioral Sciences, established the Spanish Family Guidance Center in Miami in the 1970s to provide services to the local Hispanic community, which was predominately Cuban. The Spanish Family Guidance Center's work has grown in response to the needs of the minority community in Miami. In particular, work with youth with behavior problems has expanded to include minority families from a variety of backgrounds, including both Hispanic (from the Caribbean Islands and Central and South America) and African American youth and families.

To accommodate this expansion, the Center for Family Studies was established as an umbrella organization to serve inner-city minority youth and families in Miami. The mission of the Center for Family Studies is to identify the needs of minority families and develop and refine culturally appropriate interventions to meet those needs. The Center for Family Studies combined Brief Strategic Family Therapy and Bicultural Effectiveness Training into a package called Family Effectiveness Training.

Brief Strategic Family Therapy (BFST)
The Center for Family Studies uses BSFT to help children and adolescents with conduct, delinquency, and other behavior-related problems, including alcohol and substance abuse. To improve youth behavior, BSFT attempts to change family interactions and cultural / contextual factors that influence youth behavior problems. BSFT is based on the fundamental assumption that the family is the "bedrock" of child development; the family is viewed as the primary context in which children learn to think, feel, and behave. Family relations are thus believed to play a pivotal role in the evolution of behavior problems and, consequently, they are a primary target for intervention.

BSFT recognizes that the family itself is part of a larger social system and - as a child is influenced by her or his family – the family is influenced by the larger social system in which it exists. At the broadest level, BSFT recognizes the influence of cultural factors in their development and maintenance of behavior problems.

Bicultural Effectiveness Training
The center for Family Studies developed the bicultural effectiveness training intervention to enhance bicultural skills in all family members. Bicultural effectiveness training is specifically designed to ameliorate the acculturation-related stresses confronted by two-generation immigrant families (Szapocznik, Santisteban, et al., 1984). A clinical trial investigated the relative effectiveness of bicultural effectiveness training in comparison to BSFT (Szapocznik, Santisteban, Rio, Perez-Vidal, Krutines, & Hervis, 1986) in improving behavior problems in early adolescence and family functioning. The results of this study indicated that bicultural effectiveness training was as effective as structural family therapy in improving adolescent and family functioning.

Family Effectiveness Training
Subsequently, BSFT and bicultural effectiveness training were combined into a package called Family Effectiveness Training (Szapocznik, et al., 1986). A study investigated the effectiveness of family effectiveness training as a prevention / intervention strategy for Hispanic families of children 6-11 who presented emotional and behavioral problems (Szapocznik, Santisteban, et al., 1989).

The results of this study indicated that families in the Family Effectiveness Training treatment group showed significantly greater improvement than did control families on measures of family functioning, problem behaviors, and child self-concept. Thus, the intervention was able to improve both child and family functioning. The improvements were still in effect at six-month follow-up.

Risk Factors Addressed

Family conflict
Antisocial behavior

Protective Factors Addressed

Skills: Parenting

CSAP Strategy

Education
Information dissemination

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Hispanic parents of children exhibiting problems
- African American parents of children exhibiting problems

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the change in level of conflict in the family.
- Assess the level of problem behaviors in the children of participating parents.

Research Conclusions

(Excerpts from materials provided by the Center for Family Studies, University of Miami.)

Results indicate that families in the FET Program showed significantly greater improvement than did control families on independent measures of structural family functioning, on problem behaviors as reported by parents, and on a self-administered measure of child self-concept. Furthermore, the results of the follow-up assessments indicated that the effects of the FET intervention were maintained over time.

Costs and Special Considerations

Please contact the Center for Family Studies for information on costs and special considerations.

Contact Information

For technical assistance, training and materials:

Carleen Robinson Batista
University of Miami
Center for Family Studies
1425 NW 10th Avenue, 3rd Floor
Miami, FL 33136

E-mail: crobins2@med.miami.edu

Phone: 305.243.4592

Fax: 305.243.5577

BEST PRACTICE: Family Therapy (General)

Description of Best Practice

(Excerpt from *Family Centered Approaches*, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocols System, pp. 18-19.)

This prevention approach targets families at high risk because they face multiple risk factors or have a high level of exposure to a particular risk factor. The interventions in this approach are designed to improve family functioning and reduce juvenile delinquency, recidivism, child abuse, and other strong antisocial behaviors.

Family therapy helps family members develop interpersonal skills and improve communication, family dynamics, and interpersonal behavior. It can be used to help family members improve their perceptions about one another, decrease negative behavior, and create skills for healthy family interaction. It can also be used to enhance parenting skills and reduce inappropriate parental control over children.

Expected Changes and Key Activities
The expected changes in this prevention approach all focus on improving family functioning and reducing children's recidivism and other problem behaviors. All activities focus on changes in:

1. Families – Increasing mutual positive reinforcement and decreasing maladaptive interaction patterns, improving family dynamics in families with juvenile offenders or adolescents with strong antisocial behaviors, acquiring skills, improving communication, learning effective discipline methods, and learning self-management skills.
2. Youth – Reducing behavioral and emotional problems and repeat offender rates, improving the functioning of juvenile offenders, and preventing the initiation of substance abuse.

Activities include various types of family-centered therapies used with diverse groups of clients. The following illustrate some of the therapies and groups treated:

1. Functional family therapy, used by paraprofessional therapists and foster care caseworkers for families with seriously delinquent youth (Alexander and Parsons 1982)
2. Structural family therapy, used for Hispanic families with boys diagnosed as having opposition disorder, conduct disorder, adjustment disorder, or anxiety disorder (Santisteban et al. 1995)
3. Multi-systemic family-ecological therapy for families with juvenile offenders (Henggeler et al. 1986; Henggeler, Melton, and Smith 1992)

Risk Factors Addressed

Persistent antisocial behavior
Family management problems

Protective Factors Addressed

Skills
Bonding to family

CSAP Strategy

Education
Information dissemination

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

Not defined

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the level of communication between parent-child
- Assess family management skills
- Assess parental knowledge about how to reduce antisocial child behavior
- Assess level of family bonding, including perceptions and attitudes of parents and adolescents about each other

Research Conclusions

(Excerpt from *Family Centered Approaches*, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocols System, p. 19.)

The research and practice evidence reviewed indicates that it is possible to implement family therapy for families with children who are at high risk of substance abuse:

There is medium evidence that family therapy results in enhanced parenting skills, improved family communication, increased parental knowledge about how to reduce antisocial child behavior, improved perceptions and attitudes of parents and adolescents about each other, and reduced inappropriate control of parents over adolescents.

There is strong evidence that family therapy reduces recidivism in delinquent teenagers.

Note: The criteria used to rate the strength of evidence for each prevention approach are shown in Appendix A [in the source document].

Contact Information

For more information, order a copy of CSAP's *Family Centered Approaches* from:

National Technical Information Systems
Phone: 800.553.6847

Practitioners Guide cost: $29.50, order #PB 98159692
Reference Guide cost: $58.00, order #PB 99101800

BEST PRACTICE: Focus on Families

(Catalano et al)

Description of Best Practice

(Excerpt from *Preventing Drug Use Among Children and Adolescents,* National Institute on Drug Abuse, 1997, pp. 26-27.)

A program for parents receiving methadone treatment and for their children, Focus on Families has a primary goal to reduce parents' use of illegal drugs by teaching them skills for relapse prevention and coping. Parents are also taught how to manage their families better. The parent training consists of a 5-hour family retreat and 32 parent training sessions of 1.5 hours each. Children attend 12 of the sessions to practice developmentally appropriate skills with their parents.

Session topics include:

- Family goal-setting
- Relapse prevention
- Family communication
- Family management
- Creating family expectations about alcohol and other drugs
- Teaching children skills (such as problem-solving and resisting drug offers)
- Helping children succeed in school

Booster sessions and case-management services also are provided.

Risk Factors Addressed

Family management problems
Parental attitudes and involvement

Protective Factors Addressed

Skill building
Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Parents receiving methadone treatment and their children

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. However, comprehensive tools are available at an approximate copying cost of $50.00. Data analysis is not provided.

The following are suggested areas to assess when implementing this practice:

- Determine a decrease in parents' drug use
- Determine an increase in parenting skills

Research Conclusions

(Excerpt from *Preventing Drug Use Among Children and Adolescents,* National Institute on Drug Abuse, 1997, p. 27.)

Early results indicate that parents' drug use is dramatically lower and parenting skills significantly better than are seen in control groups; the program's effects on children have not yet been assessed, however.

Costs as of May 2001 (Subject to Change)

Training Time: When available, it is anticipated to be 24 hours.

Training Costs: Undetermined

Note: Training is under development through THS Training Institute, Seattle, Washington. The training will provide specific skills for working with the population and with direct issues of program implementation.

Strategy Implementation (1996 costs):
$3,444 per client family

This includes the cost of staff, childcare providers, office rent, telephone, travel, photocopy and other consumable supplies, and participant incentives.

Special Considerations

Please consider the following before selecting this strategy for your community:

- This is a program that is targeted at parents in methadone treatment.
- It requires role-playing and videotape and comprehensive case management.
- It is more than just buying a curriculum and implementing it. It is making family a part of the treatment process and working with drug abusers on parenting skills.

Contact Information

For training, materials and technical assistance:

Raymond Hummel
Therapeutic Health Services Training Institute
Phone: 206.323.0930

For additional program information, visit web site:
http://depts.washington.edu/sdrg

Or contact:

Kevin Haggerty
Social Development Research Group
University of Washington
9725 3rd Ave NE, Suite 401
Seattle, WA 98115-2024
E-mail: haggerty@u.washington.edu
Phone: 206.543.3188
Fax: 206.543.4507

BEST PRACTICE: Functional Family Therapy

(Alexander and Parsons)

Description of Best Practice

(This excerpt provided by the *Functional Family Therapy Project*, November 2000.)

Functional Family Therapy (FFT) is well-documented family prevention and intervention program that has been applied successfully to a wide range of problem youth and their families in various contexts. Functional Family Therapy (FFT) is an empirically grounded intervention program that targets youth between the ages of 11 and 18, although younger siblings of referred adolescents also benefit from the program.

FFT is a short-term intervention with sessions from, on average, 8 to 12 one-hour sessions for mild cases and up to 26-30 hours of direct service for more difficult situations. In most programs sessions are spread over a three-month period of time.

Target populations range from at-risk preadolescents to youth with very serious problems (such as conduct disorder) youth representing multi-ethnic, multicultural populations. FFT has been successful with a range of delinquent and substance abusing youth.

The data from numerous outcome studies suggests that when applied as intended, FFT can reduce recidivism between 25% and 60%. Additional studies suggest that FFT is a cost-effective intervention that can, when appropriately implemented, reduce treatment costs well below that of traditional services and other family-based interventions.

The major goals of Functional Family Therapy are to:

1) Engage and motivate youth and their families by decreasing the intense negativity so often characteristic of these families

2) Reduce and eliminate the problems behaviors and accompanying family relational patterns that put family and youth at risk through individualized behavior change plans that target the improvement of family communication, parenting, and problems solving skills

3) Generalize changes across problem situations by increasing the family's capacity to adequately utilize community resources

The FFT model is appealing because of its clear identification of specific intervention phases, each with a description of goals, requisite therapist characteristics, and techniques. The phases of interventions help organize therapy into a coherent manner allowing clinicians to maintain focus in the context of considerable family and individual disruption.

Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills. Through these phases, FFT combines a strong cognitive / attributional component, which is integrated into systematic skill-training in family communication, parenting, and conflict management skills.

As a clinical model FFT has been conducted in clinical settings as an outpatient therapy and in clients homes as a home-based model. The fidelity of the FFT model is achieved by a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability. The FFT Practice Research Network (FFT-PRN) allows clinical sites to participate in the development and dissemination of FFT model information.

Risk Factors Addressed

Family management problems
Family conflict
Persistent antisocial behavior

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

First time delinquent and pre-delinquent youth

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
The tool is included in the overall training cost. Sites are required to purchase the POSIT ($75 CD-ROM) the FAM-III ($25 for 25 forms) and the limited OQ.45 site license ($15 for 15 people, $8 for each additional manual and $500 license fee). The CSS is a computer-based monitoring and tracking tool to be used in measuring adherence and clinical outcomes. Outcome measures are built into this system.

The following are suggested areas to assess when implementing this practice:

- Assess decreased recidivism rate
- Assess increased parental skills
- Assess decreased family conflict

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, page 68.)

The program has demonstrated impact on reducing delinquency in targeted teenagers and 18 month follow-up studies suggest that the impact is lasting. The program has a preventive influence on the younger siblings. It is one of the

few family-focused programs which has been tested for effectiveness with adolescent status-offenders.

Costs as of December 2001 (Subject to Change)

Training Time: Site certification is a one-year process

Training Costs:
$24,500 per site for entire training package plus travel expenses

Note: The standard training program targets working groups at community implementation sites. FFT has a three-phase certification process usually lasting three years. Site certification is required of community agencies hoping to implement FFT as a clinical model. Potential sites need to submit an application for site certification. (Please see "Special Considerations.")

Strategy Implementation:
$2,000 per family. Sites are required to purchase the POSIT, the FAM-III, and the limited OQ.45 site license. These costs are minimal.

Special Considerations

Please consider the following before selecting this strategy for your community:

- FFT can be delivered as an in-home or in-office intervention.
- Certification allows both individuals and sites to participate in ongoing research, training, and service implementation activities.
- Site certification is a one-year process involving:
  - Three-day clinical training for all FFT therapists in a working group
  - Externship training for one working group member (will become the clinical lead for the working group)
  - Follow-up visits (usually three, one to two days on-site)
  - Supervision Consultations (four hours of monthly phone consultation)
  - Clinical Services System

Contact Information

For more information on Functional Family Therapy, visit web site:
http://www.fftinc.com

For technical assistance, training and materials:
Kathie Shafer, Project Manager
E-mail: shafer@csbs.utah.edu
Phone: 801.585.1807

For questions related to Functional Family Therapy, contact:
James F. Alexander, Ph.D.
Department of Psychology
University of Utah
390 S. 1530 E., Room 502
Salt Lake City, UT 84121
E-mail: jfafft@psych.utah.edu

Tom Sexton, Ph.D.
Department of Counseling and Educational Psychology
Indiana University
201 North Rose Avenue
Bloomington, IN 47405
E-mail: thsexton@indiana.edu
Phone: 812.856.8350

For implementation and site certification contact:
Doug Kopp, National Implementation Director
FFT Inc.
2538 57th Ave SW
Seattle, WA 98116
E-mail: dkfft@msn.com

For a copy of the "Blueprint" summary for this program (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies, Cost: $15 per copy) contact:
Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442
Phone: 303.492.8465
Web site: *http://www.colorado.edu/cspv/blueprints*

BEST PRACTICE: Healthy Families America

Description of Best Practice

(Excerpts from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html* and updated with information from Prevent Child Abuse America's web site: *http://www.healthyfamilisamerica.org/index.html*)

Prevent Child Abuse America (PCA America), formerly known as the National Committee To Prevent Child Abuse, sponsors the Healthy Families America home visiting initiative in 420 sites across the nation. The Healthy Families is a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services including child development, access to health care and parent education. The program serves families identified as at-risk, with children 0-5 years.

Program goals include prevention of negative birth outcomes (low birth weight, substance abuse, criminal activity, child abuse and neglect), increased parenting skills, healthy pregnancy practices, and the use of social systems. Assessments are conducted either prenatally or at the time of birth. Home visiting can begin either prenatally or within 90 days after birth. The Family Support Worker (FSW) visits at least once a week for up to one year. The FSW helps establish support systems, teaches problem-solving skills, enhances positive parent-child interaction, and offers information, education and referrals to community resources. Once a family is in the program, they can receive services for up to five years.

Risk Factors Addressed

Family management problems
Constitutional factors

Protective Factors Addressed

Bonding – Family
Skills – Parenting

CSAP Strategy

Education
Problem identification and referral

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Parents with children ages 0-5, facing multiple challenges (e.g. elements that would add stressors to any home:
- Single parent status
- Low income
- Substance abuse problems
- Victim of abuse or domestic violence, etc.

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy. However, the credentialing process that Healthy Families America uses ensures fidelity of the implementation of the program.

The following are suggestions of areas you may want to assess if you implement this best practice:

- Assess change in family management skills by parent participants
- Assess rate of child maltreatment by parent participants
- Assess level of positive parent-child interaction patterns in participant families

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

In 1992, Healthy Families America moved forward with the home visiting model based on a comprehensive evaluation, using an experimental design that was conducted with 372 families in the Hawaii Healthy Start program. The results indicate that early and intensive home visitation by paraprofessionals produces measurable benefits for participants in the areas of parental attitudes toward children, parent-child interaction patterns, and type and quantity of child maltreatment. Mothers who received home visits significantly reduced their potential for physical child abuse and showed significant positive changes in maternal involvement and sensitivity to child cues. Treatment families exhibited more positive parent-child interaction patterns at both six- and twelve-month assessment points.

Cost

Please visit the following web site for information about training time and cost:
http://www.healthyfamiliesamerica.org/services/training.html

Implementation Cost:
Please contact the organization listed below for information on implementation cost.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- An Application for Affiliation is completed by new programs to ensure that Healthy Families is a good fit for them and their community.

Please contact Healthy Families America for more information.

Contact Information

For more information on this program, visit web site:

http://www.healthyfamiliesamerica.org and

http://ojjdp.ncjrs.org/pubs/fact.html#fs200123 and

(click on "Healthy Families America")

For technical assistance, training and materials, contact:

Healthy Families America
200 S. Michigan Avenue, Suite 1700
Chicago, IL 60604

Phone: 312.663.3520

Fax: 312.939.8962

BEST PRACTICE: Home Instruction Program for Preschool Youngsters

Description of Best Practice

(Excerpt from materials provided by HIPPY USA.)

The Home Instruction Program for Preschool Youngsters (HIPPY) is a home-based parent involvement, school readiness program. It helps parents of three-, four- and five-year-old children prepare their children for success in school and beyond.

The two basic tenets of HIPPY are that:

1. All children can learn
2. All parents want what's best for their children

The HIPPY program is made up of four basic features:

1. The curriculum, which (for each year) includes: thirty weeks of activities (five days for each week) for parents to do with their children, nine storybooks and 20 manipulative shapes
2. The home visitors, who are paraprofessional staff and themselves parents in the program, supervised by a professional coordinator
3. Role-play as the method of teaching the curriculum, both when coordinators train home visitors and when home visitors work with parents
4. Home visits as the primary method of delivery, but with group meetings that allow parents to meet and discuss / learn about common issues and children to interact with other children in a supervised environment

Parents of three- and four-year-old children are recruited into the program by the HIPPY coordinator, who chooses some of the parents to hire as home visitors. The home visitors "practice" doing HIPPY with their own child and then visit each of their case load of families (10-15 per part-time home visitor) on a bi-weekly basis, to role-play the upcoming week's curriculum, review the previous week's activities, and discuss any issues the parent may have. On the weeks when no home visit takes place, a group meeting is held and role-play of the curriculum takes place with parents as a group and then an enrichment activity (chosen by the parents) is conducted. Once the group meeting is over, or the home visit has taken place, the parent works, one-on-one, with his / her child for 15-20 minutes per day for five days.

The program started in Israel in 1969 and has since spread to Turkey, Germany, Chile, Mexico, New Zealand, South Africa and the United States (in 1984). Each country, culture and language makes its own adaptations to the HIPPY model, in order to implement it effectively in its community. However, the four features of the HIPPY model – the essence of the HIPPY program – remain the same. The implementation of the HIPPY model, and in particular the HIPPY curriculum, is continually updated and improved, based on relevant research and on feedback from program participants.

In program year 2000-2001, there were 161 HIPPY sites in 29 states, the District of Columbia and the Territory of Guam. HIPPY served 16,307 children with 892 home visitors. The racial / ethnic compositions of our service recipients were: 39% African American, 27% Caucasian, and 30% Hispanic / Latino. A "typical" HIPPY program serves 150 families with one coordinator and 10-12 part-time home visitors. HIPPY USA is the national office for the network of HIPPY programs in the United States, with the primary responsibilities of providing training and technical assistance; developing and improving the curriculum and the implementation of the HIPPY model; outreach, advocacy and national collaborations; and national data collection and evaluation initiatives.

Risk Factors Addressed

Academic failure

Protective Factors Addressed

Skill building

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Parents of three-, four-, and five-year-old children

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy.

The following suggestion is an area you may want to assess if you implement this best practice:

- Assess academic performance of children after they are in elementary school

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

Evaluations on classroom adaptation, paraprofessionals' growth and development, program implementation, model validation, and children's outcomes at end of second grade have all shown positive effects from participation in the program. Broad differences in measured competence and classroom behavior favoring HIPPY children over children with no formal preschool experience were found. There were no differences between HIPPY children and children with other types of formal preschool experience.

Costs as of December 2001 (Subject to Change)

Training Time: Five days

Training Costs:
- $850 for the first person from an agency / organization
- $600 for the second person from the same agency organization
- $340 administrators / supervisors attending the training for two full days

The initial pre-service training is five days long and is required of all new coordinators and programs. On-going training and technical support is at the foundation of HIPPY. All coordinators have an assigned National Trainer to mentor and assist them. A national conference is held yearly and is attended by all coordinators, HIPPY USA staff, trainers, and many paraprofessionals.

Strategy Implementation:
HIPPY is estimated to cost $500 - $1,600 per child per year, based on average program size of 60 families in the first year and 120 families in the second year, a full-time coordinator and one paraprofessional for each group of 12 families. The 1999 - 2000 cost per child of implementing this strategy was $1,267. Programs with low costs generally receive significant in-kind donations. Costs vary based on size and location, urban or rural settings.

These figures cover:
- Salaries for staff
- Fees for training and technical assistance
- License and affiliation
- Program development
- Cost of curriculum materials
- Travel
- Conference attendance
- Supplies
- Other direct costs

Curriculum materials may only be purchased once a formal contractual agreement has been signed with HIPPY USA. The HIPPY Start-Up Manual can be obtained free of cost, or a HIPPY order form by e-mail: info@hippyusa.org. The manual provides detailed information on the steps to implementation, budget considerations and the application form.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Additional trainings are offered by state and regional programs assisted by HIPPY USA staff and national trainers.
- Curriculum / materials are written on a third-grade reading level.
- Curriculum is available in English and Spanish.
- HIPPY can be implemented in both urban and rural settings, in a variety of host agencies:
  - Public schools
  - Public housing projects
  - Community-based service organizations
  - Universities

Contact Information

For outreach materials or more information, visit web site:
www.hippyusa.org

For training information
M. Gayle Hart, Director of Training
E-mail: mghart@hippyusa.org
Phone: 800.208.7228

For more information:
Melinda Devaney
HIPPY USA
220 East 23rd Street, Suite 300
New York, NY 10010
E-mail: info@hippyusa.org
Phone: 212.532.7730
Fax: 212.532.7899

BEST PRACTICE: Home Visiting

Description of Best Practice

(Excerpt from *Preventing Crime: What Works, What Doesn't, What's Promising,* University of Maryland, Department of Criminology and Criminal Justice and the U.S. Department of Justice, Office of Justice Programs, 1997, pp. 4-10 through 4-15.)

Home visitation varies enormously in dosage levels, content, skill, and context. Yet there are common effects reported across all these variations. The common core of home visitation is a visitor who cares about child-raising sitting down in a home with a parent and a child. Visitors can be nurses, social workers, preschool teachers, psychologists, or paraprofessionals. They can provide cognitive information, emotional support, or both. They can actively teach parents, with hands on the children. Or they can passively watch and listen, merely giving parents a good listening to. They can be trained in health (like nurses), human development (like psychologists and social workers), cognitive and social skills instruction (like preschool teachers), or some mixture of these subjects (like paraprofessionals). They can be experienced or novice, enthusiastic or burned out, assertive or hesitant. But no matter who they are or what they do, they provide a bridge between the parent, usually a mother, and the outside world.

While the two long-term experiments included preschool programs (also called "day care" in some studies) positive effects were found in 11 of the experiments from home visitation without preschool. Some of the home visitations included doctor's office visits or some other contexts for instruction and observation outside the home, but most did not. None of the five experiments showing that home visitation reduced child abuse included involvement in preschool.

The consistent finding of beneficial effects of home visits without preschool is important for several reasons. One reason is theoretical: it shows that the visits are not simply a spurious correlate of the effects of preschool programs on both the children and their mothers, who in some studies are heavily involved in the preschool programs and who show beneficial effects themselves in reduced welfare support and longer time between pregnancies.

The fact that one trial (Wasik et al., 1990) found stronger effects from home visits with cognitively-oriented day care than from home visits to comparison families (of which more than half were in some other kind of day care) does not contradict the independent effects of home visits. Yoshikawa (1994) and others have concluded that home visits are likely to be more effective in combination with early education, but the empirical evidence may still be too preliminary to reach a conclusion either way.

(For a specific example of a home visiting program, see Prenatal/Early Infancy Project.)

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family
Opportunities and skills

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Low income
- Caucasian
- African American
- Hispanic/Latino
- Children of high-risk mothers

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess increased in family management skills
- Assess increased family bonding
- Assess decrease in child abuse rates

Research Conclusions

(Excerpt from *Preventing Crime: What Works, What Doesn't, What's Promising,* University of Maryland, Department of Criminology and Criminal Justice and the U.S. Department of Justice, Office of Justice Programs, 1997, pp. 4-10 through 4-15.)

Figure 4-2 [in *Preventing Crime: What Works, What Doesn't, What's Promising,* p. 4-11 through 4-14] summarizes the results of 18 different evaluations of programs that included a home visitation component. The figure and this discussion draws primarily on the material in Yoshikawa's (1994) review, as well as Tremblay and Craig's review (1995) and the draft OJJDP review prepared by Wasserman and Miller (forthcoming). All of them show positive effects of home visits on either some measure of crime by children when they enter adolescence (N = 2 experiments) child abuse during or shortly after the period of home visits (N = 5 experiments) or risk factors for delinquency (N = 10 experiments, 1 meta-analysis).

While the meta-analysis of Head Start evaluations (McKey, et al., 1985) shows that the measured effects wear off, that analysis includes the lowest dosage of home visits of any of the experiments: as few as two per year. In contrast, the substantial reductions in later delinquency in the two long-term follow-up studies are associated with weekly home visits for periods up to five years.

Even if home visits were more effective in combination with other prevention efforts, the evidence of their independent

effects has practical implications. The Hawaii State Healthy Start program, for example (U.S. Advisory Board, 1995: 129) which reaches more than half of all Hawaiian newborns, operates on a $7 million annual budget as a home visit program only. The evidence reviewed in figure 4-2 suggests that the Hawaiian program is likely to be effective at reducing child abuse, as would Federal funding of home visit programs nationally. Whether they would be effective at preventing delinquency or serious crime in later life by the children visited cannot be determined without longer-term studies.

Child abuse and neglect is a risk factor for delinquency, however, associated in one prospective study with a 50 percent increase in prevalence and a 100 percent increase in frequency of adolescent arrests (Widom, 1989). Thus, if the results of the home visitation experiments can be generalized to other settings, they could clearly reduce a delinquency risk factor. The effect sizes in these evaluations are particularly impressive. Both of the long-term delinquency prevention effects are on the magnitude of a relative reduction of three-quarters less prevalence of official criminal histories.

Costs and Special Considerations

Not available

Contact Information

For more information on this best practice, you can order a free copy of *Preventing Crime: What Works, What Doesn't, What's Promising,* University of Maryland / Department of Criminology and Criminal Justice and the U.S. Department of Justice / Office of Justice Programs, 1997, from:

National Criminal Justice Reference Service
Phone: 800.851.3420

For a copy of a summary of the "Blueprint" for this program (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies, Cost: $10 per copy) contact:

Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442

Phone: 303.492.8465

Web site: *http://www.colorado.edu/cspv/blueprints*

BEST PRACTICE: Home-Based Behavioral Systems Family Therapy

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html* and updated by Don Gordon in December 2001.)

This program's long-range objectives include:

Reduced child involvement in juvenile justice system
Reduced self-reported delinquency
Reduced teen pregnancy
Reduced special class placement
Increased graduation rates
Increased employment

Intermediate objectives include:

Decreased family conflict
Increased cohesion
Improved communication
Improved parental monitoring, discipline, and support of appropriate child behavior
Improved problem solving abilities
Improved parent-school communication
Improved school attendance and grades
Improved child adjustment

Dr. Gordon's model has been applied to multiply offending, institutionalized delinquents, and targets families with low educational levels and high levels of pathology. Modifications were made for families in Appalachia and for inner-city African American families.

The program is delivered in 5 phases:

1. Introduction / Credibility
2. Assessment
3. Therapy
4. Education
5. Generalization / Termination

In the early phases, therapists are less directive and more supportive and empathic than in the later phases, when the family's cooperation and resistance is more conducive to increased therapist directiveness. Percentage of therapist-family contact time devoted to each phase is approximately: 5 % Introduction; 15% Assessment; 45% Therapy; 25% Education; and 10% Generalization / Termination.

Risk Factors Addressed

Persistent antisocial behavior
Family management problems
Academic failure

Protective Factors Addressed

Bonding — Family

CSAP Strategy

Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- Institutionalized delinquent youth with multiple offenses and their families
- Inner-city African American families
- Families in Appalachia (a rural area)

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess change in family management skills
- Assess youth's recidivism rate
- Assess school attendance, grades, and graduation rates of youth participants
- Assess family cohesion
- Assess child behavior

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

The first evaluation was based on treatment of twenty-seven 14- to 16-year-old, court selected delinquents who were considered likely to recidivate and / or to be placed out of the home.

After a two to two-and-a-half year follow-up period, recidivism for the treatment group was 11% vs. 67% for the control group. The subjects in this study were followed for another 32 months into adulthood. The treatment group showed a 9% recidivism rate for criminal offenses vs. 45% for the control group.

The second evaluation was conducted with forty juveniles referred to the treatment program because they were the most serious, chronic offenders in the county.

Upon an average of 18 months following the end of treatment, 30% of treated delinquents re-offended and 12% required another institutional commitment. A constructed statistical control group, based upon risk of recidivating, would be expected to have a 60-75% recidivism rate, and a recommitment rate of 50-60%. The large difference between actual and expected rates indicate a robust treatment effect, not due to chance.

Costs as of December 2001 (Subject to Change)

Strategy Implementation:

- Two therapist manuals, 170 and 38 pages, can be copied and cost $11.50 for the two per trainee.
- In addition, parent workbooks for the Parenting Wisely program are given to each family treated. These workbooks (100 pages) that are used in the education phase, need to be ordered from Dr. Gordon, and cost $9 each.
- Instructional videotapes for therapists are available at cost, approximately $5 each for two.
- A set of three parenting skill training tapes, the Parenting

Wisely video series, which can be used repeatedly, costs $250.

For training costs, please contact Dr. Gordon.

Contact Information

For more information, visit:

Web site: *http://www.familyworksinc.com*

or contact:

Donald A. Gordon, Ph.D.
Psychology Department
Ohio University
Athens, OH 45701

E-mail: gordon@ohiou.edu

Phone: 541.201.7680

BEST PRACTICE: Houston Parent-Child Development Center

Description of Best Practice

(Excerpts from information provided by Dale L. Johnson, Ph.D., Department of Psychology, University of Houston, Houston, TX)

The Houston Parent-Child Development Center was developed to assist low-income, Mexican American families in helping their children to do well in school and to foster intellectual and social competence. The program was designed to provide a wide range of educational and support services, to deliver these services in ways that were responsive to the families' poverty, and to be sensitive to their culture. Evaluation of the program has demonstrated success in reducing the incidence of behavior problems and enhancing school performances five to eight years after completion of the program.

Elements of the two-year program include:

Year One

- In-Home Visits: 25 one and a half hour visits by paraprofessional educators teaching infant development topics.
- Family Workshops on Sundays or Weekends: Small groups of differing configurations receive training on communication, decision making, and on issues suggested by participants.
- English as a Second Language: Classes for mothers and referrals for fathers.
- Community Services: transportation to workshops, education on attaining resources, and information on family planning, child health and public health centers provided by a visiting nurse.

Year Two

- Center-Based Activities: 4 hours, 4 mornings a week for mothers and their two-year-old children, with transportation and lunch provided.
- Child Care Management: Continuation of year-one topics in group discussion formats with greater emphasis on authoritative parenting and problem behavior management, and attaining feedback from participating parents who practiced newly learned skills.
- Home Management: Mothers learn skills in budgeting, meal planning, and on participant requested topics such as driver education and human sexuality.
- Nursery School: Two-year-olds are encouraged to explore and to develop new peer relationships.
- Teachers stimulated cognitive development by posing questions and problem-solving situations.
- Parent Advisory Committee (PAC): monthly evening meetings for fathers result in successfully strong, active paternal roles.

Risk Factors Addressed

Early antisocial behavior
Academic failure
Family management problems

Protective Factors Addressed

Bonding: Family
Skills: Social competence

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Low-income Mexican American families and their children ages birth to three

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy.

The following is a suggested area to assess when implementing this practice:

- Assess mother's use of praise, warmth, encouragement of child verbalization, and provision of a cognitively stimulating home environment

Research Conclusions

(Excerpts from information provided by Dale L. Johnson, Ph.D., Department of Psychology, University of Houston, Houston, TX)

A primary prevention program, the Houston Parent-Child Development Center, directed towards infants and their parents, has effectively reduced the frequency of behavior problems for these children five to eight years after the program's completion.

- Teacher ratings showed significantly fewer acting-out, aggressive behaviors for program children.
- Ratings of classroom behaviors found program children to be significantly less hostile and more considerate than control children.
- Program boys were less dependent than control boys.
- Program children had higher school achievement test scores than control children and these differences persisted into high school.

Costs as of December 2001 (Subject to Change)

Training Time:
Variable, dependent upon individual implementation needs

Special Considerations

Please consider the following before selecting this strategy for your community:

- Manuals are available and consultation can be provided on their use.

Contact Information

For information, technical assistance, and materials contact:

Dale L. Johnson, Ph.D.
Department of Psychology
University of Houston
Houston, TX 77204-5341

Or alternate address:
831 Witt Road
Taos, NM 87571

E-mail: dljohnson@uh.edu

Phone: 505.758.7962

Fax: 713.743.8633

BEST PRACTICE: The Incredible Years Parent and Children Videotape Series

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 40-41.)

Program Objectives
Short-term objectives for parents are to improve communication skills with their children, improve limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short-term objectives include reduction of the frequency and number of conduct problems and improvement of pro-social skills.

Program Strategies
The basic and advanced series consists of 15 videotape programs, each building on the last. Five two-hour sessions are usually required to complete the first two programs, though some groups may take longer. Most parent groups take 12-14 weeks (2 to 2 1/2 hours per week) to complete the basic series (9 videotapes). The advanced series takes an additional 6-19 sessions (6 videotapes). Groups usually range from 10 to 14 participants; one trainer is needed per group. On-site day care is recommended for those parents who cannot arrange or afford baby-sitting.

Recruitment and Retention
Families at risk for abuse or with a history of abuse or child misconduct problems may be referred by therapists or clinicians.

Staffing
While the program has been researched with extensively trained and experienced therapists, it could be used by many groups in the community who work with families (e.g., teachers, parent educators, nurses, physicians, child protective service workers, etc.) Professional backgrounds of instructors who have used the program include advanced degrees in psychology, social work and nursing. Instructor training is through self-study with the leader's manual and videotapes provided with the program. Training workshops are offered; duration has varied from one day to two weeks, depending on the background and experience of the leaders-in-training, and on the nature of the families they work with. Workshop costs vary depending on length.

Resources Needed and Materials Available
The complete program includes videotapes, an instructor's manual, and a set of manuals for the participants. The leader's guide for the parents and children series contains a brief recap of the parent / child interactions and the author's narration for each vignette, a summary of the important points, topics for discussion, and all of the necessary checklists and forms for administering the program. The leaders guide also describes how to use the parents and children series as a self-administered program or with groups. The participants' workbooks for each of the video cassettes contain all of the information needed by participants using the basic program in a self-administered format. This workbook contains all of the checklists, forms, and handouts for using the parents and children series. The complete program costs $1,300. Individual programs cost $175 - $245 each.

Comments on Implementation/Replication
This program should be fairly easy to implement, due to the extensive materials available.

In 1992, three new programs (5 videotapes) were produced for school-aged children, including parent models representing over 50% of families from differing cultural backgrounds. The purposes of these programs are to promote parents' self-confidence and competence in using positive parent management strategies in order to promote children's social skills, support their academic success, increase their self-esteem and reduce inappropriate behavior at home and at school.

A new five-part videotape program focuses on helping parents understand ways to support their children's education. It includes promoting self-confidence, fostering good learning habits, dealing with academic discouragement, parents participating in homework, and using parent-teacher conferences to advocate for your child.

New Videotapes for Children
The *Dinosaur Social Skills and Problem-Solving Curriculum for Young Children* is designed to promote non-aggressive ways for children to solve common conflicts, appropriate classroom behaviors, and positive social skills with other children and adults. It contains 9 videotapes, teacher manuals, letters to parents, and 40 laminated teaching materials.

Risk Factors Addressed

Family management problems
Early antisocial behavior

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal
Selective

Populations Appropriate for This Best Practice

- Parents of children aged 2-8 years
- Parents of oppositional children aged 3-8 years
- Parents at risk of abuse or neglect
- Teenagers taking baby-sitting classes or family life classes
- Family therapists, social workers, child psychologists, teachers, nurses, physicians, child protective service workers, and day care providers.

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
There is no cost for the evaluation tool.

The following are suggestions of areas you may want to assess if you implement this best practice:

- Assess the increase in family management skills.
- Assess decrease in children's behavior problems and increase in their pro-social behavior.

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 41)

The series has been researched and field tested with over 600 families, including normal children and those with conduct problems (Webster-Stratton, 1981, 1982, 1989, 1990, 1991).

Results indicate that:

- Parents were able to significantly reduce children's behavior problems and to increase their pro-social behavior.
- Parents reported that they felt more confident and comfortable about their parenting skills after completing the course.
- One to three year follow-up assessments indicate that more than two-thirds of the clinic-referred (i.e., abusive, conduct-disordered) families continued to maintain positive parent-child interactions and normal child behavior.

Costs as of December 2001 (Subject to Change)

Training Time:
3 days (21 hours) – Parent Training

2 days (14 hours) – Child Training

Training Cost:
$1,300 per day plus travel expenses, lodging, per diem, and other expenses.

Note: There are tips for hosting a successful workshop that can be provided.

Materials Cost:
$1,300 plus shipping for materials plus training costs: (Basic)

$775 plus shipping and handling, plus training if not already done: (Advance)

$995 plus shipping and handling, plus training if not already done: (School Age)

$975 plus shipping and handling, plus training cost: (Dina Dinosaur Program for Small Group Therapy)

$1,075 plus shipping and handling, plus training cost: (Dina Dinosaur Classroom Curriculum)

Strategy Implementation:
Cost varies

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- Childcare needs of parents should be considered

Contact Information

For training, materials, and more information visit web site:
http://www.incredibleyears.com

or contact:

Lisa St. George, Administrative Director
The Incredible Years
1411 8th Avenue West
Seattle, WA 98119

E-mail: incredibleyears@seanet.com

Fax and Phone: 206.285.7565 or
888.506.3562

BEST PRACTICE: Keep a Clear Mind

Description of Best Practice

(Excerpt from CSAP's Model Program web site *http://modelprograms.samhsa.gov*)

Keep A Clear Mind (KACM) is a parent/child substance abuse prevention program for families with children in grades four through six. This home-based program developed by the University of Arkansas uses a correspondence format and consists of four weekly lessons on alcohol, tobacco, marijuana, and tools to avoid drugs. KACM's overall goal is to increase parent/child communication regarding drug prevention and to develop specific youth beliefs and skills to refuse and avoid "gateway" drug use.

The KACM program uses classroom lessons, incentives, and, in some cases, newsletters. Each of these services is described below.

Classroom Lessons
Each of the lessons provides a brief introduction to the weekly topic, followed by a sequence of five activities to be completed at home with a parent. The activities include answering simple questions about the harms of drug use and the prevalence of peer drug use, listing reasons not to use drugs, writing "no" statements to resist pro-drug use social pressures, selecting the best ways to refuse and avoid drugs from a list of alternatives, and completing contracts to refuse and avoid drugs. KACM lessons are designed to be introduced at the beginning of the week by the classroom teacher or a community agency staff member. Finished lessons are to be returned by the end of the week.

Incentives
Incentives are provided for students returning completed lessons within an indicated time period. Generally, lessons go home on Monday and a sheet for parents indicating that lessons have been completed is returned on Friday. Some incentives have included tickets to sports events, bookmarks, folders, stickers, and pens.

Newsletter
Parent newsletters are sent home biweekly over a 10-week period, following the initial four lessons. Newsletters prompt parents to provide encouragement to their children and to reinforce the importance of "saying no to drugs." The newsletters also provide parents with specific tips for communication with their children.

Risk Factors Addressed

Favorable attitudes toward drug use
Parental attitudes toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards
Skills: Social skills and refusal skills

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Students in elementary school grades 4, 5, and 6 and youth in non-school settings of the same age, and their parents.

Evaluating This Best Practice

This best practice comes with an evaluation tool, available upon request, that can be used when implementing this strategy.

Evaluation Tool Cost:
Data analysis and written report are negotiated on an individual basis.

The following are suggested areas to assess when implementing this practice:

- Assess change in parental and youth attitudes toward drug use
- Assess social skills and refusal skills gained by youth participants

Costs as of May 2001 (Subject to Change)

Training is not necessary to implement this program. However, training is available upon request.

Training Time: One-half day

Training Cost: $1,000 plus travel

Strategy Implementation: $3.95 per participant

This strategy implementation cost figure includes the following: Keep A Clear Mind Lessons, parent newsletters, and incentives (bookmarks, bumper stickers, pencils, and other).

Special Considerations

None identified by program developer

Research Conclusions

(Excerpt from *Journal of Drug Education*, 1996, Vol. 26, Number 1, pp. 57-68.)

Students
Students in the KACM groups were more likely than students in the control group to move toward a no-use position. Similarly for two items related to peer use, students in the two KACM groups were more likely to change toward a more realistic view of the situation. Additionally, students in the KACM groups were more apt to move to a realization that tobacco does have harmful effects on young people and to perceive their parents as having a negative view of marijuana use.

Parents
When compared to parents in the control group, parents in the two KACM groups were more likely to express that their child had an increased ability to resist pressure to use the substance addressed in the KACM program, a decreased expectation that their child would try these substances, a more realistic view of their use among young people, and a greater realization of the harmful effects.

Student Perception
Two other items to show significant change were concerned with student perception of peer alcohol and tobacco use. A number of students had mistakenly thought that "most kids" use these substances on a daily basis but made a more accurate assessment of the situation after exposure to accurate information. This is an important finding in that children's expectancies regarding peer drug use is considered one of the processes influencing their own use.

Expected Use
The final two items to show change were those dealing with expected use of cigarettes and snuff. Students in the KACM groups reported a decreased likelihood of using these substances when compared to students in the control group.

Contact Information

For more information on this program, visit web site:
http://modelprograms.samhsa.gov

Also visit web site:
http://www.uark.edu/depts/hepoinfo/clear.html

For additional information, materials or a free program sample contact:

Martha Hamman
University of Arkansas
HPER 326A
Fayetteville, AR 72701
E-mail: mhamman@mail.uark.edu
Phone: 501.575.5639
Fax: 501.575.6401

For training inquiries contact:

Dr. Michael Young
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Fax: 501.575.6401

BEST PRACTICE: Life Skills Training Program

(Botvin et al)

(Excerpt from *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse,* 1997, pp. 21-22 with updates provided by the Life Skills program staff.)

The Life Skills Training universal classroom program is designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. The program consists of a three-year prevention curriculum intended for middle school or junior high students. It contains 15 periods during the first year, 10 booster sessions during the second, and five sessions during the third.

Three major content areas are covered by the Life Skills Training program:

- Drug resistance skills and information
- Self-management skills
- General social skills

Drug resistance skills and information provides material that deals directly with the social factors promoting drug use. This content area includes material designed to:

- Increase awareness of social influences toward drug use
- Correct the misperception that everyone is using drugs and promote anti-drug norms
- Teach prevention-related information about drug abuse
- Teach drug resistance skills

The self-management content areas provides students with skills for increasing independence, personal control and a sense of self-mastery through teaching:

- Skills for increasing self-control and self-esteem (such as self-appraisal, goal-setting, self-monitoring and self-reinforcement)
- General problem-solving and decision making skills
- Critical thinking skills for resisting peer and media pressures
- Adaptive coping strategies for relieving stress and anxiety

This area includes teaching:

- General problem-solving and decision making skills
- Critical thinking skills for resisting peer and media influences
- Skills for increasing self-control and self-esteem (such as self-appraisal, goal-setting, self-monitoring, self-reinforcement)
- Adaptive coping strategies for relieving stress and anxiety

General social skills enhance students' social competence with a variety of general skills including:

- Effective communication
- Overcoming shyness
- Learning to meet new people
- Developing healthy friendships.

These skills are taught through a combination of instruction, demonstration, feedback, reinforcement, behavioral rehearsal, and extended practice through homework assignments.

Risk Factors Addressed

Favorable attitudes toward drug use
Friends who use

Protective Factors Addressed

Healthy beliefs and clear standards
Skills: Social competence

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- 6-8th grade or 7-9th grade
- Caucasian
- African American
- Hispanic / Latino

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
There is no cost presently for the tool. Life Skills Training Program does not provide data analysis services.

The following are suggested areas to assess when implementing this practice:

- Assess decreased use of alcohol, tobacco and marijuana
- Assess change in favorable attitudes toward drug use
- Assess skills gained in area of social competence

Research Conclusions

(Excerpt from *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide, National Institute on Drug Abuse,* 1997, page 22 with updates provided by the Life Skills program staff.)

The Life Skills Training program has been extensively studied over the past 20 years.

Results indicate that:

- Research shows that this prevention approach can produce a reduction in tobacco, alcohol and marijuana use from 59% to 87% relative to controls.
- Booster sessions can help maintain program effects.
- Long-term follow-up data from a randomized field trial involving nearly 6,000 students from 56 schools found significantly lower smoking, alcohol, and marijuana use 6 years after the initial baseline assessment.
- The prevalence of cigarette smoking, alcohol use, and marijuana use for the students who received the Life Skills Training program was 44 percent lower than for control students, and the regular (weekly) use of multiple drugs was 66 percent lower.
- Although the early research with the Life Skills Training program was conducted with white populations, several recent studies show that it is also effective with inner-city minority youth.
- It also has been found effective when implemented under different scheduling formats and with different levels of project staff involvement.
- Finally, evaluation studies indicate that this prevention program works whether the program providers are adults or peer leaders.

Costs as of May 2001 (Subject to Change)

Training Time: 14 hours

Training Cost:
$200 per person (plus $100 for the cost for curriculum material)

Materials Cost:
$275 for a level 1 curriculum set (1 Teacher's Manual, 30 Student Guides and a relaxation audiocassette tape)

Please view the following web site for more details on cost:
http://www.lifeskillstraining.com/ordering.html

Special Considerations

Please consider the following before selecting this strategy for your community:

- The program is usually implemented in schools.

Contact Information

For more information on this program, visit web sites:
http://modelprograms.samhsa.gov
http://www.lifeskillstraining.com

Also contact:
Chris Williams, Ph.D.
141 South Central Avenue, Suite 208
Hartsdale, NY 10530
E-mail: cwilliams@nhpanet.com
Phone: 914.421.2525
Fax: 914.683.6998

For training and technical assistance, contact:
Wendy Amer-Hirsch
E-mail: wamerhirsch@nhpanet.com
Phone: 914.421.2525 or
800.293.4969
Fax: 914.683.6998

To order or preview the Life Skills Training curricula, contact:
Princeton Health Press Inc.
115 Wall Street
Princeton, NJ 08540
E-mail: PHPinfo@aol.com
Phone: 800.636.3415
Fax: 609.942.3593

For a summary copy of "Blueprint" (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies) for this program (Cost: $15.00 per copy) contact:
Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442
Phone: 303.492.8465
Web site: *http://www.colorado.edu/cspv/blueprints*

BEST PRACTICE: Meld

Description of Best Practice

(Excerpt from materials provided by Meld, December 2001.)

Meld programs bring parents with common needs together into groups that meet over two years. They learn, grow, and become friends while solving problems and creating healthy families. Volunteer group facilitators are experienced parents who are carefully selected, trained and supported by a Meld professional in each community.

Data gathered from participants shows that, even when parents are at very high risk for possible abuse or neglect, Meld makes parenting work: non-custodial fathers in the Meld for Young Dads program establish paternity, contribute financially, and spend time with their children; Hmong parents become involved in their children's schools, despite language and cultural barriers; and more young, single mothers in the Meld for Young Moms program avoid second teen pregnancies than do other teenage mothers across the country.

Meld replicates its programs in new communities by certifying agency professionals to coordinate local programs and train local volunteers. Program coordinators receive training, consultation, and materials that guide program management. Meld's network of certified professionals shares information, ideas, support, and a common belief in the essential components of the Meld program. Meld provides these sites with ongoing support and supervision while giving local efforts national visibility.

Meld offers nine programs that use the peer-led self-help model of parents learning from each other:

1. Meld for Young Moms: Information and support for young single moms with children from birth to age two.
2. Meld for Young Dads: Helping young fathers (up to age 25) understand and participate in their child's life.
3. Meld for New Parents: First-time parents learn about child development from birth through age 2.
4. Meld Special: Support for parents of children with special needs, from birth to age 3.
5. Meld for Growing Families: Information and support for young moms with children age 3 to 5.
6. Meld for Hmong Parents: Parents explore how cultural differences affect their children's integration into American life.
7. Meld para la Nueva Familia: For Hispanic/Latino immigrant families struggling with bilingual/bicultural issues.
8. Meld for African American Young Mothers: Culturally appropriate support and information for adolescent African American mothers.
9. Meld for East African Parents: Culturally specific information and support to assist the Twin Cities' East African immigrant parents.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding – Family
Skills – Parenting

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Parents of preschool children
- Young single mothers and single fathers
- Hispanic parents
- Southeast Asian parents
- African American young moms
- East African parents
- First-time adult parents
- Parents of children with special needs

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. Each "Evaluation Manual" is designed to meet the needs of the site coordinator. The manual contains a program evaluation history, literature review for the individual program, goals, process forms and outcome forms. Evaluation Tool Cost: $30.00.

The following are suggested areas to assess when implementing this practice:

- Assess change in family management skills
- Assess parents' belief in the value of corporal punishment

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

Meld's success is enhanced by its careful replication processes which have moved the program into over 150 communities. Training, technical assistance and curriculum focus on quality program development and the achievement of program outcomes. A seven site study of the Meld for Young Moms program demonstrated a positive and significant shift in attitudes and beliefs toward parenting and nurturing children.

Results include:

- More appropriate expectations of child's abilities
- Increased empathic awareness of child's needs and appropriate response
- Reduced belief in the value of corporal punishment
- Awareness that the child does not exist to please and love the parent, rather that the parents' purpose is to respond to the needs of the child.

These attitudes are notably linked to what is known about characteristics of parent-child relationships that prevent child abuse and neglect, thus juvenile delinquency. Other Meld programs produce similar results, with evident impacts on reduction of isolation, decreased depression, and increased knowledge of child development.

Costs as of December 2001 (Subject to Change)

Training Time: Varies

The replication and certification fee is $18,000 total for two years. This figure includes program materials, training and technical support.

A sample budget provided by Meld outlines a cost of $57,182 for year 1 and $66,526 for year 2. This includes budgets for staff, training, local travel, replication and certification fee, reimbursement for parent group facilitators, group expenses, telephone, printing / copying, space / utilities, and office supplies.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Close contact is maintained with each site coordinator before program implementation to determine the appropriateness of the program.

Contact Information

For more information on training, visit:
Web site: *http://www.meld.org*

or contact:
Nancy Clutter
Meld
219 N. Second Street, Suite 200
Minneapolis, MN 55401
E-mail: nclutter@meld.org
Phone: 612.332.7563 x109
Fax: 612.344.1959

For additional information, contact:
Teri Holgate
Meld
219 North Second Street, Suite 200
Minneapolis, MN 55008
E-mail: tholgate@meld.org
Phone: 612.332.7563 x 111
Fax: 612.344.1959

BEST PRACTICE: Mentoring – Big Brothers/Big Sisters

Description of Best Practice

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, *http://www.colorado.edu/cspv/blueprints/model/ten_Big.httm)*

Big Brothers / Big Sisters (BBBS) is a community mentoring program which matches an adult volunteer, known as a Big Brother or Big Sister, to a child, known as a Little Brother or Little Sister, with the expectation that a caring and supportive relationship will develop. Hence, the match between volunteer and child is the most important component of the intervention. Equally important, however, is the support of that match by the ongoing supervision and monitoring of the match relationship by a professional staff member. The professional staff member selects, matches, monitors, and closes the relationship with the volunteer and child, and communicates with the volunteer, parent / guardian, and the child throughout the matched relationship.

In practice, the volunteer intervention in the traditional one-to-one relationship with a child is three to five hours per week, on a weekly basis, over the course of a year or longer. The generalized activity of that relationship is related to the goals that were set initially when the match was established. These goals are identified from the extensive case manager interview held with the parent / guardian and with the child. The foremost goal usually set is to develop a relationship—one that is mutually satisfying, where both parties come together freely on a regular basis. More specific goals might relate to school attendance, academic performance, relationships with other children and siblings, general hygiene, learning new skills or developing a hobby. The goals established for a specific match are developed into an individualized case plan, which is updated by the case manager as progress is made and circumstances change over time.

Generally speaking, BBBS agency staff do not tell a volunteer specifically what activities to engage in with the child during their time together, but they guide the volunteer and make suggestions of possible activities and approaches, based on the child's and volunteer's interests and needs. Consistency in the relationship over time is a higher priority than the types of activities in which they participate.

Once the match has been initially agreed upon, in the presence of the child, volunteer, and the child's parent / guardian, it is then the responsibility of the professional staff member, known as the case manager, to maintain on-going contact with all parties in the match relationship.

The Standards and Required Procedures for One-To-One Service outlines the schedule of contacts the case manager is to have with the volunteer, as well as with the parent and / or child. There is to be more frequent contact during the early stages of the match with an initial contact within two weeks of making the match, then monthly contact throughout the rest of the year, and then contact every three months after the first year and throughout the duration of the match. The case manager calls the volunteer and the parent after the first and second week of the relationship to determine how the relationship is developing, and may continue on a weekly basis through the first six weeks, depending on the situation. However, it eventually develops into a monthly contact with the volunteer and the parent.

At least quarterly, the case manager is in touch with the child to learn of the youth's experiences. These supervisory contacts inform the case manager how the relationship is developing and provide an opportunity to give advice and guidance around any issues the volunteer might have, as well as to encourage and support various activities. For most agencies, the on-going case manager supervision with the volunteer takes place over the phone. The case manager is to assess the match goals on an annual basis and make appropriate adjustments to the case plan.

The Standards and Required Procedures for One-To-One Service also describes the professional practice the case manager is to follow throughout the intervention process with the volunteer, parent, and child, including maintaining confidentiality and case records.

Program Content:
Service delivery is by volunteers who interact regularly with a youth in a one-to-one relationship. Agencies use a case management approach, following through on each case from initial inquiry through closure. The case manager screens applicants, makes and supervises the matches, and closes the matches when eligibility requirements are no longer met or either party decides they can no longer participate fully in the relationship.

BBBSA distinguishes itself from other mentoring programs via rigorous published standards and required procedures:

- *Orientation* is required for all volunteers.
- *Volunteer Screening* includes a written application, a background check, an extensive interview, and a home assessment; it is designed to screen out those who may inflict psychological or physical harm, lack the capacity to form a caring bond with the child, or are unlikely to honor their time commitments.
- *Youth Assessment* involves a written application, interviews with the child and the parent, and a home assessment. It is designed to help the caseworker learn about the child in order to make the best possible match, and also to secure parental permission.
- *Matches* are carefully considered and based upon the needs of the youth, abilities of volunteers, preferences of the parent, and the capacity of program staff.
- *Supervision* is accomplished via an initial contact with the parent, youth, and volunteer within two weeks of the match; monthly telephone contact with the volunteer, parent and / or youth during the first year; and quarterly contact with all parties during the duration of the match.

For more information on Big Brothers / Big Sisters, visit:
http://www.colorado.edu/cspv/blueprints/model/ten_Big.htm

Risk Factors Addressed

Early initiation of the problem behavior
Early and persistent antisocial behavior
Low commitment to school

Protective Factors Addressed

Bonding: Adults with healthy beliefs and clear standards
Healthy beliefs and clear standard

CSAP Strategy

Alternatives

Type of Strategy

Selective

Populations Appropriate for This Best Practice

10-16 years old

Evaluating This Best Practice

The following is a suggestion of areas you may want to assess if you implement this best practice:

- Assess initiation of alcohol, tobacco, and other drug use by participants
- Assess the likelihood that participants hit other children
- Assess the academic behavior, attitude, and performance of participants.
- Assess the quality of relationships between participants and their parents or guardians.

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, *http://www.colorado.edu/cspv/blueprints/model/ten_Big.htm*)

An evaluation of the BBBSA program has been conducted to assess children who participated in BBBSA compared to their non-participating peers. After an eighteen month period, BBBSA youth were:

- *46% less likely than control youth to initiate drug use* during the study period.
- *27% less likely to initiate alcohol* use than control youth.
- *almost one-third less likely than control youth to hit someone.*
- *better than control youth in academic behavior, attitudes, and performance.*
- more likely to have *higher quality relationships with their parents or guardians than control youth.*
- more likely to *have higher quality relationships with their peers* at the end of the study period than did control youth.

Costs and Special Considerations

None identified

Contact Information

For more information on this program, contact your local Big Brothers / Big Sisters Association or the national office:

Joseph Radalet
230 North 13th Street
Philadelphia, PA 19107

E-mail: national@bbbsa.org

Phone: 215.567.7000

Fax: 215.567.0394

Web site: *www.bbbsa.org*

For a copy of the "Blueprint" summary for this program (step-by-step instructions that will help communities plan and implement youth crime and violence prevention strategies, Cost: $10 per copy) contact:

Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442

Phone: 303.492.8465

Web site: *http://www.colorado.edu/cspv/blueprints*

BEST PRACTICE: Multi-Component School-Linked Community Approaches

(Tobacco Specific)

Description of Best Practice

(Excerpt from *Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners*, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp.16-20.)

The primary goal of this prevention approach is to discourage adolescent tobacco use by mobilizing community systems through school-based programs. Within this prevention approach, the research and practice evidence is divided into three clusters each with its own emphasis: parent involvement, student antitobacco activism, and media interventions.

CLUSTER 1: Parent Involvement
Research demonstrates that multi-component programs are more effective than single-component interventions for preventing tobacco use among adolescents. Adding parental involvement to a school-based prevention program should therefore increase the effectiveness of the school-based program.

Activities
- Parent surveys
- Take-home quizzes for parents and students
- Letters to parents
- Smoking cessation services and self-help materials for parents
- Television segments on smoking prevention and cessation
- Pamphlets for parents containing information about teen tobacco problems
- Educational materials for parents with tips on how to encourage their kids not to smoke
- Parent training
- Community organizing to develop school policies discouraging tobacco use and to institute drug prevention curricula
- Community organizing to promote community change regarding use of alcohol, tobacco, and illicit drugs by adolescents
- Media campaign to support other programs components

CLUSTER 2: Student Antitobacco Activism
Research demonstrates that multi-component programs are more effective than single-component interventions in preventing tobacco use among adolescents. Adding student antitobacco activism as a component to a school-based prevention program should, therefore, increase the effectiveness of the school-based program. Student antitobacco activism is defined as participation in planned and structured activities designed to raise awareness, provide education, or prompt social changes relating to tobacco use among youth.

Activities
- Writing letters to: members of a favorite sports team, asking them not to use or endorse tobacco products; a restaurant manager or owner, advocating smoke-free restaurants; film producers and magazine editors protesting tobacco advertising
- Holding poster contests
- Creating antitobacco art projects
- Making floats and participating in community parades and festivals
- Writing and singing antitobacco songs
- Revising school policies regarding tobacco use
- Planning and attending a culturally specific youth health day
- Designing and painting an antitobacco mural at a junior high school
- Participating in the production of antitobacco animated videos, in debates regarding tobacco issues, and in the development of a smoking education curriculum

CLUSTER 3: Media Interventions
Research demonstrates that multi-component programs are more effective than single-component interventions in preventing tobacco use among adolescents. Adding media-based interventions to a school-based prevention program should therefore increase the effectiveness of the school-based program.

Activities
- Mass-media events such as press conferences, interviews, talk shows, and articles
- Daily 5-minute television segments featuring smoking prevention that are coordinated with school curricula
- Curricula and other written information on the hazards of tobacco use for students, teachers, and parents
- Mass-media antitobacco advertisements and public service announcements

Risk Factors Addressed

Community laws and norms favorable toward drug use
Favorable attitudes toward drug use
Parental attitudes favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Information dissemination
Education
Community-based process

Type of Strategy

Universal

Populations Appropriate for This Best Practice

No specific populations

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess change in adolescents' attitudes and beliefs regarding tobacco
- Assess changes in adolescent tobacco use rate

Research Conclusions

(Excerpt from *Reducing Tobacco Use Among Youth: Community-Based Approaches: A Guideline for Prevention Practitioners,* Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocols System Series 1, pp. 16-20.)

Level of Evidence
CLUSTER 1
The research and practice evidence reviewed indicates that it is possible to implement multi-component prevention programs that combine parental involvement components with other prevention efforts, such as school-based programs:

- There is medium evidence that multi-component, school-linked programs with a parental component promote (1) improved parental knowledge about adolescent tobacco use, (2) the development of negative attitudes by parents toward tobacco use, and (3) the mobilization of parents to speak with their children about not using tobacco.
- There is medium evidence that these programs change students' perceptions regarding tobacco use.

CLUSTER 2
The research and practice evidence reviewed indicates that it is possible to implement prevention programs that involve student activism:

- There is medium evidence that adolescents can be mobilized to participate in antitobacco activism within schools and the community.
- There is medium evidence that student activism is effective in improving adolescents' knowledge about tobacco and in promoting negative attitudes regarding tobacco use.
- There is suggestive but insufficient evidence that student activism is effective in preventing adolescent tobacco use because few studies have assessed this outcome.

CLUSTER 3
The research evidence reviewed indicates that it is possible to develop adolescent tobacco use prevention programs utilizing media components in combination with other prevention efforts (such as school-based programs):

- There is medium evidence that exposure to media-based antitobacco interventions, in concert with school-based tobacco education, can change adolescent students' knowledge, attitudes, and beliefs about tobacco use and industry marketing practices.
- There is medium evidence that multi-component prevention programs that include media-based interventions are effective in preventing adolescent tobacco use.

Lessons Learned From Reviewed Evidence

- Programs designed to enhance the effectiveness of school-based curricula result in increased family and student attention to antitobacco messages. However, there is limited evidence that these programs reduce tobacco use among youth.
- The effects of a fully implemented school- and community-based intervention (including parental involvement) to reduce adolescent tobacco use as part of a broader substance abuse prevention strategy may be limited by the community's view of tobacco use as a minor issue in relation to other forms of substance abuse and the likelihood that addressing adolescent tobacco use will not be considered a priority.
- The effectiveness of multi-component prevention programs may be related to the multiplicative effect, that is, the net effect of a program may be greater than the sum of the individual effects of the program components. In other words, the ways in which program components interact with each other and their effects on each other are largely unknown. As a result, it may not be feasible to assess the independent contributions of each component.
- Students who voluntarily participate in school-based antitobacco activism projects may not be at high risk for using tobacco. The program, therefore, may be focused disproportionately on those who are already at low risk.

Costs and Special Considerations

None identified

Contact Information

For more information on this best practice, order a free copy of the following publications from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at:

Phone: 800.729.6686, or

Web site: *http://ncadi.samhsa.gov*

Reducing Tobacco Use Among Youth: Community-Based Approaches, Center for Substance Abuse Prevention, 1997, Prevention Enhancement Protocol System Series 1, publication order no. "PHD 745" (Prevention Practitioners Guide) and "PHD 746" (full document).

BEST PRACTICE: Multisystemic Therapy Program

Description of Best Practice

(Excerpt from Strengthening America's Families' web site: *http://www.strengtheningfamilies.org/index.html*)

Multisystemic therapy (MST) is an intensive family-based treatment that addresses the known determinants of serious antisocial behavior in adolescents and their families. As such, MST treats those factors in the youth's environment that are contributing to his or her behavior problems. Such factors might pertain to individual characteristics of the youth (e.g., poor problem-solving skills), family relations (e.g., inept discipline), peer relations (e.g., association with deviant peers), and school performance (e.g., academic difficulties). On a highly individualized basis, treatment goals are developed in collaboration with the family, and family strengths are used as levers for therapeutic change. Specific interventions used in MST are based on the best of the empirically validated treatment approaches such as cognitive behavior therapy and the pragmatic family therapies. The primary goals of MST are to reduce rates of antisocial behavior in the adolescent, reduce out-of-home placements, and empower families to resolve future difficulties.

Several programmatic features are crucial to the success of MST:

- The use of a home-based model of service delivery (i.e., low caseloads, time limited duration of treatment) removes barriers of access to care and provides the high level of intensity needed to successfully treat youths presenting serious clinical problems and their multi-need families.
- Second, the philosophy of MST holds service providers accountable for engaging the family in treatment and for removing barriers to successful outcomes. Such accountability clearly promotes retention in treatment and attainment of the treatment goals.
- Third, outcomes are evaluated continuously, and the overriding goal of supervision is to facilitate the clinicians' attempts to attain favorable outcomes.
- Fourth, MST programs place great emphasis on maintaining treatment integrity, and as such, considerable resources are devoted to therapist training, ongoing clinical consultation, service system consultation, and other types of quality assurance.

Note: Some funding agencies may classify this as an "intervention" or "treatment" program and may, consequently, not fund it with prevention dollars.

Risk Factors Addressed

Family management problems
Antisocial behavior

Protective Factors addressed

Bonding – Family
Skills

CSAP Strategy

Education

Type of Strategy

Indicated

Populations Appropriate for This Best Practice

- Chronic, violent, or substance abusing juvenile offenders at high risk of out-of-home placement and their families
- 10-18 years old

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. It is a fidelity measure that has been shown to be predictive of long-term outcomes.

Evaluation Tool Cost: No cost.

The following are suggestions of areas you may want to assess if you implement this best practice.

- Assess change in family management skills
- Assess rate of criminal activity and incarceration of youth participants
- Assess rate of out-of-home placements of youth participants
- Assess mental health problems for youth participants

Research Conclusions

(Excerpt from MST's' web site, *http://www.mstservices.com/text/treatment.html*)

Evaluations of MST have demonstrated:

- Reduced long-term rates of criminal offending in serious juvenile offenders
- Reduced rates of out-of-home placements for serious juvenile offenders
- Extensive improvements in family functioning
- Decreased mental health problems for serious juvenile offenders
- Favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services

Cost as of December 2001 (Subject to Change)

Training Time:
Program support and training in MST is provided on-site by MST Services, Inc. using essentially the same protocol that has been used in successful clinical trials of MST with violent and chronic juvenile offenders. Prior to receiving

training, program development and start-up technical assistance on-site meetings are held. Therapists and supervisors receive training in MST in three ways. First, five days of intensive on-site orientation training are provided. Second, 1.5-day "booster" sessions occur on-site on a quarterly basis. Third, treatment teams and their supervisors receive weekly telephone consultation from MST experts.

Training Cost:
In addition to the elements of clinical training, the package of program support and training services includes a pre-training site assessment, assistance with program specification and design (including the development of quality control and outcome tracking system) and ongoing assistance with overcoming barriers to achieving successful clinical outcomes. The cost of program support and training is based on an all-inclusive annual per team fee. Fees range from $15,000 to $24,000 per team, plus travel expenses based upon the nature and size of the program. Also, an annual $5,000 license fee is required, regardless of the number of teams, and each individual within that organization using MST (therapists and supervisors only) pay an annual license fee of $200 per person.

Staff training in MST is an on-going process. A primary objective of MST Services is to assist organizations in building capacity to provide for part or all of their MST program's long-term training needs. In this context, program support and training expenses should be viewed as the annual cost of a Quality Assurance (QA) program. Based upon an average annual service capacity of 15 families per therapist per year, the total long-term QA costs (program support and training) is usually in the range of $400 to $550 per youth served.

Implementation Cost:
Multisystemic Therapy (MST) is conducted by therapists who are part of a MST "team." Two to four MST therapists and their on-site supervisor make up a MST team which works together for purposes of group and peer supervision, and to support the 24 hour/7 day/week on-call needs of the team's client families. MST therapists are full-time master's-level or highly clinically-skilled bachelor's-level mental health professionals. MST supervisors are typically assigned to the program a minimum of 50% time and may carry a small caseload if assigned full-time. MST supervisors are either doctoral-level or highly competent Master's-level professionals.

MST staff must be highly accessible to their clients and often have both pagers and cellular phones. Typically MST programs budget for mileage reimbursement to cover 8,000 to 12,000 miles a year per therapist. Internet access for administrative staff is required for scoring of required Quality Control measures. It is recommended that a small amount of flexible funds be available to the MST team ($100 per client family) for occasional and/or emergency needs. An annual program-licensing fee is required and is based upon the size of the MST program.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- MST Services conducts a site assessment process to assure that MST is a good fit for your needs.
- Complete the "Go, No-Go" questionnaire on MST's web site (*http://www.mstservices.com/text/go_nogo.htm*) to assist in determining how ready your organization is to proceed with an MST implementation.

Contact Information

For more information on MST visit web site:
http://www.mstservices.com

For information on training and technical assistance, contact:

Marshall E. Swenson, MSW, MBA
Manager of Program Development, MST Services
Post Office Box 21269
Charleston, SC 29413-1269
E-mail: ms@mstservices.com
Phone: 843.856.8226 x14
Fax: 843.856.8227

BEST PRACTICE: NICASA Parent Project

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

The Parent Project was designed specifically to meet the needs of working parents in the workplace environment to address issues of effective parenting.

The goals of the program are to enrich family relationships and promote healthy environments that build resistance to social and personal dysfunction. Specifically, it focuses on the need to:

- Establish supportive networks among working parents
- Improve parent/child relationships
- Increase ability to balance work and family life
- Improve corporate climate for workers
- Improve parent skills in preventing and identifying substance abuse problems in themselves and their children

The Parent Project includes programs for parents with children of the following ages: birth to 4 years old, elementary school age, and adolescents.

The program has also been modified and piloted at three work sites to address specific issues related to single working parents. The program is presented at lunch time at a worksite.

At each developmental level, the program addresses issues common to all parents such as:

- Balancing work and family
- Communication
- Discipline
- Learning styles
- Sibling relationships
- Sex role conditioning
- Substance abuse and others

The program also focuses on specific developmental stage issues such as:

- Child care
- Tantrums
- Sleeping and eating patterns
- Communicating with school personnel
- Peer pressure and establishing family substance use policies for elementary school children
- School performance
- Male/female relationships and increasing levels of responsibility for adolescents

Risk Factors Addressed

Family management problems
Favorable parental attitudes toward drug use

Protective Factors Addressed

Skills – Parenting

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Parents of children ages birth to 4
- Parents of children in elementary school
- Parents of adolescent children
- Single working parents

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
There is no additional cost for the evaluation tool which is provided at the trainings.

The following are suggested areas to assess when implementing this practice:

- Assess change in family management skills
- Assess change in parents' negative attitudes toward drugs
- Assess change in negative child behaviors

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html*)

- In a longitudinal study of 191 parents using a quasi-experimental design, parents in a high dosage group reported significant and enduring changes in child behaviors, and rated child behavior more positively.
- Parenting practices and knowledge changed significantly in the desired direction, parental punitiveness and irritability declined, and parental stress and depression were reduced.
- There were positive increases in substance abuse knowledge and negative attitudes toward drugs, for parents who received high dosage levels of the program.

Costs as of May 2001 (Subject to Change)

Training Time: Two and one-half days

Training Cost:
- $3,000 per trainer

- $155 per person for two manuals and extra materials
- Extra costs such as shipping, lodging, meals, travel

Note: The training includes information regarding marketing, philosophy, working with corporate culture, cultural adaptations for community programs, reaching diverse populations, and working with the parents' situation (long hours etc.). Much of the training is experiential.

Special Considerations

Please consider the following before selecting this strategy for your community:

- The program is conducted in the community workplace on the lunch hour
- The handouts are for high school graduates

Contact Information

For more information, training, and / or technical assistance, contact:

Joyce Millman, MA
Northern Illinois Council on Alcoholism and Substance Abuse (NICASA)
31979 North Fish Lake Road
Round Lake, IL 60073

E-mail: joycemil@attbi.com or jmillman@nicasa.org
Phone: 847.546.6450, Ext. 232
Fax: 847.546.6760

BEST PRACTICE: Norms for Behavior and Rule Setting in School

(Gottfredson)

Description of Best Practice

"Norms for Behavior and Rule Setting in Schools" is a type of strategy that has been used in several different programs / projects. This strategy has been tested and shown effective in the following projects. Please review these programs to see how to implement this strategy: Project PATHE, Project CARE, and Project BASIS.

(Excerpt from *Preventing Crime: What Works, What Doesn't and What's Promising*, Office of Justice Programs' Research Report, by University of Maryland, Department of Criminology and Criminal Justice, 1997, pp. 5-15.)

Program components necessary for effective implementation

- Increasing clarity of rules and consistency of rule enforcement through revisions to school rules and computerized behavior tracking system
- Improving classroom organization and management through teacher training
- Increasing the frequency of communication with the home regarding student behavior through systems to identify good student behavior and a computerized system to generate letters to parents regarding both positive and negative behavior
- Replacing punitive disciplinary strategies with positive reinforcement of appropriate behavior through a variety of school and classroom level positive reinforcement strategies

Risk Factors Addressed

Lack of commitment to school
Community laws and norms favorable toward drug use

Protective Factors Addressed

Healthy beliefs and clear standards

CSAP Strategy

Environmental

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Elementary and middle schools

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess pre and post incidences of targeted behavior, i.e. bullying, vandalism, drug use
- Assess pre and post incidences of disciplinary action for problem behavior
- Assess pre and post teacher reporting of classroom disturbances
- Assess decrease in delinquent behavior

Research Conclusions

(Excerpt from *Preventing Crime: What Works, What Doesn't and What's Promising*, Office of Justice Programs' Research Report, by University of Maryland, Department of Criminology and Criminal Justice, 1997, pp. 5-16.)

Programs aimed at setting norms or expectations for behavior, either by establishing and enforcing rules or by communicating and reinforcing norms in other ways, have been demonstrated in several studies of reasonable methodological rigor to reduce alcohol and marijuana use and to reduce delinquency. Note, however that schools where rules were manipulated also used school teams to plan and implement the programs, so it is not possible to separate the specific effects of school rules and discipline strategies from the more general effects of encouraging teams of school personnel to solve their schools' problems.

Costs and Special Considerations

Not applicable

Contact Information

To implement this strategy, review the following programs / projects: Project PATHE, Project CARE, Project BASIS.

BEST PRACTICE: Nurse Family Partnership

(Formerly Prenatal/Early Infancy Project)

Description of Best Practice

(Excerpted with permission from: Developmental Research and Programs. *Communities That Care Prevention Strategies: A Research Guide to What Works,* 1996, pp. 11-12.)

The Prenatal/Early Infancy Project was a comprehensive research project targeting young, unmarried mothers in a semi-rural Appalachian region of New York that had high rates of poverty and child abuse. The project included multiple interventions, such as home visitations by a nurse from pregnancy through age two, health education for parents, job and educational counseling, parent training, and social service linkages through referral and advocacy systems. Home visitors encouraged close friends and family members to participate in the home visits, and to help mothers with child care and household responsibilities.

The prenatal and infant health care component of the program involved screening and referral, home visits every two weeks during pregnancy, free transportation to well-child care clinics, and continued nurse visitation until the children were two years old. Registered nurses, who had participated in a three-month training program, worked in two-person teams to deliver the program.

(Citation listed in CTC publication: Olds, D.L., C.R. Henderson, Jr., R.L. Tatelbaum, MD. & R. Chamberlain, MD. Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation. Pediatrics (January, 1986) vol. 77 No. 1.)

(Citation for 15-year follow-up study: Olds DL, Eckenrode J, Henderson CR, Kitzman H, Powers J, Cole R, Sidora K, Morris P, Pettitt LM, & Luckey D. Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: A Fifteen-Year Follow-up of a Randomized Trial. Journal of the American Medical Association. (August 27, 1997) Vol. 278, No. 8. 637-643.)

Risk Factors Addressed

Extreme economic deprivation
Favorable parental attitudes toward the problem behavior
Family management problems
Constitutional factors

Protective Factors Addressed

Healthy beliefs and clear standards
Bonding: Opportunities, skills and recognition

CSAP Strategy

Information dissemination
Problem identification and referral
Community-based process

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Rural
- Semi-rural

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
$1,000 initial installation of system, plus $5,200 per year fee for services. This figure includes:

- Initial installation of Clinical Information Software, technical assistance and trouble shooting of software and data collection problems, monthly data summary reports, guidance on self-generated reports, and annual comprehensive summary reports.

The following are suggested areas to assess when implementing this practice:

- Assess rate of child abuse and neglect for project participants compared with a non-participating group of individuals
- Assess graduation rate of participants
- Assess employment rate of participants out-of-school
- Assess whether number of subsequent pregnancies is reduced

Research Conclusions

This comprehensive program produced significant reductions in the following risk factors:

- Teen mothers and smoking mothers had fewer prenatal difficulties
- Two years after the program ended, the rate of child abuse and neglect was 4% for project participants compared with 19% for non-participating controls
- Program participants were twice as likely as controls to graduate from high school
- Older participating mothers were more likely to be employed
- Subsequent pregnancies were delayed (Olds et al., 1986; Olds and Kitzman, 1993).

A follow-up study showed that this program of prenatal and early childhood home visitation by nurses reduced the number of subsequent pregnancies, the use of welfare, child abuse and neglect, and criminal behavior on the part of low-income, unmarried mothers for up to 15 years after the birth of the first child.

Costs as of December 2001 (Subject to Change)

Training Time:
11 days total (three separate training sessions) (roughly 80 hours)

Training Cost:
Varies depending upon group size, etc. Consult with contact prior to budgeting. Approximately $2,000 per person plus travel / food / lodging.

Note: Training is required. It is a three-part series:

- Training is from the National Center for Children, Families and Communities at the University of Colorado Health Sciences Center, plus training from NCAST through the University of Washington School of Nursing.
- The first week is in Denver and covers the theory behind the program model, the Clinical Information System and the pregnancy phase of the program.
- Trainings two and three are done regionally and cover the infancy and toddler guidelines, respectively.

Strategy Implementation:
Variable – approximately $250,000 / year for 100 participants.

Special Considerations

Please consider the following before selecting this strategy for your community:

- Implementation of this program is done after a series of conversations with the National Center for Children, Families and Communities and the prospective site.
- Interested parties should contact the National Center (Matt Buhr-Vogl) as early as possible if considering this approach.
- Home Visit Guidelines necessary for program implementation are only available to sites under contract with the National Center and who are sending nurse home visitors / supervisors through our training process.

Additionally:

- Is there community support to implement the program?
- Does the community have at least 100 first-time low-income mothers who would benefit from enrolling in the program over a one-year period, and does the implementing agency have experience reaching and working with this population?
- Does the operating agency see this program as critical to achieving its mission?
- Is there sustainable financing?

Note: These and many other questions are addressed by their site development / community planning process, for which there is significant technical assistance available.

Contact Information

Note: Materials are available for approved sites only.

For training, technical assistance, additional program information contact:

Matt Buhr-Vogl, MPH
Nurse-Family Partnership
National Center for Children, Families and Communities
4200 E. 9th Ave., Box C288-13
Denver, CO 80262

E-mail: matt.buhr-vogl@uchsc.edu

Phone: 303.315.0896

Fax: 303.315.1489

Web site: *http://www.nccfc.org*

BEST PRACTICE: The Nurturing Program

Description of Best Practice

(Excerpt from the Nurturing Parenting Program in December 2001.)

The Nurturing Parenting Programs are validated, family-centered programs designed to build nurturing skills as alternatives to abusive parenting and child rearing attitudes and practices. The ultimate outcomes are to stop the generational cycle of child abuse by building nurturing parenting skills, reduce the rate of recidivism, reduce the rate of juvenile delinquency and alcohol abuse, and lower the rate of multi-para teenage pregnancies.

The Nurturing Programs address parents' needs for nurturance and re-parenting and also provide concurrent nurturing learning experiences for children. Parents and children are taught similar skills and attitudes to maximize learning and maintenance of new knowledge. Based on a re-parenting philosophy, parents and children attend separate groups that meet concurrently with cognitive and affective activities designed to build self-awareness, positive self-concept / self-esteem and empathy, to teach alternatives to yelling and hitting, enhance family communication and awareness of needs, replace abusive behavior with nurturing, promote healthy physical and emotional development and teach appropriate role and developmental expectations.

The Nurturing Parenting Programs have been field tested with families at risk for abuse and neglect, families identified by local social services as abusive or neglectful, families in recovery for alcohol and other drug abuse, families at risk for delinquency, parents incarcerated for crimes against society, and adults seeking to become adoptive or foster parents. As such, a primary use of the Nurturing Parenting Programs is to treat child and adolescent maltreatment, prevent its recurrence, and build nurturing parenting skills in at-risk populations.

There are 13 separate Nurturing Parenting Programs currently available:

- Prenatal Families
- Parents and Their Infants, Toddlers, and Preschoolers
- Parents and Their School-Age Children
- Parents and Adolescents
- Teenage Parents and Their Families
- Foster and Adoptive Parents and Their Children
- Parents with Special Learning Needs and Their Children
- Families in Substance Abuse Treatment and Recovery
- Hmong Parents and Their Adolescents
- African American Families
- Crianza con Carino programa Para Padres y Ninos (Hispanic Patents and Their Children, Birth to 5 years)
- Crianza con Carino programa Para padres e Hijos (Hispanic Parents and Their Children, 4 to 12 years)
- The ABC's Parenting Program for Parents and Children

Risk Factors Addressed

Family management problems
Family conflict

Protective Factors Addressed

Bonding: Family
Skills

CSAP Strategy

Information dissemination
Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

Families whose children are at high risk for:

- Alcohol and drug use because of a family history of alcohol and drug abuse
- Parental communication problems
- Family management problems, or youth problems
- African American, Asian / Pacific Islanders, Caucasian, Hispanic / Latino, Hmong

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
Please visit *http://www.nurturingparenting.com/aapi/index.htm* for evaluation tool cost information.

The following are suggested areas to assess when implementing this practice:

- Assess improvements in family management skills
- Assess improvements in family cohesion

Research Conclusions

(Excerpt from Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, 1993, p. 57.)

These programs have been field tested nation-wide; results of such trials are included in program materials. Nurturing Programs use the Adult-Adolescent Parenting Inventory (AAPI) as a pre / post test to measure parenting attitudes.

Costs as of December 2001 (Subject to Change)

Training Time:
2-3 days, depending on the group's level of sophistication

Training Cost:
Costs vary depending on whether the workshops are sponsored by an agency seeking to implement the Nurturing Program or whether the training is provided by the community and participants register individually. In the latter case, registration fees generally average $125 per workshop.

Implementation Cost:
- One-time purchase of complete program, which includes manuals, videos, instructional aids, and assessment in-

ventories, ranges from $875 to $1800 depending on the program purchased.

- Snacks: Weekly snacks for group programs at $20-$40 per session
- Staff time to facilitate the program
- Transportation (optional): Pick-up and drop-off of families
- Materials: Approximately $300 for each complete Nurturing Program in useables (paper, crayons, etc.)

For more details on cost, visit web site:
http://www.familydev.com/nurturing_programs.htm

Special Considerations

Please consider the following before selecting this strategy for your community:

- Assessment / evaluation tools are available which assist facilitators in gathering important information about parents when preparing to implement a class.
- Facilitators need to know if parents have any learning disabilities, past history of abuse, or issues of alcohol and drug abuse that would impact the program.
- If parents cannot read, then they would need to participate in the program for Parents with Special Learning Needs Program, instead of the program for parents and children 5-11 years.
- Implementing the program in the community may require special considerations to help people attend the program.
- Working with community leaders, providing transportation, food, child care, and medical care should be considered when setting up groups in the community.
- Professionals and paraprofessionals with training in teaching parents nurturing skills or a professional background in parent education are candidates to facilitate Nurturing Parenting Program classes. Empathy, positive self-worth, dependability, and sharing are desirable facilitator characteristics.

Contact Information

For training, consulting, materials and technical assistance, visit:

Web site: *http://www.nurturingparenting.com*

or contact:

Robert Schramm
Family Development Resources
3070 Rasmussen Rd, Suite 109
PO Box 982350
Park City, UT 98098

E-mail: fdr@nurturingparenting.com

Phone: 800.688.5822

Fax: 435.649.9599

BEST PRACTICE: Parent and Family Skills Training

(General)

Description of Best Practice

(Excerpt from *Family Centered Approaches*, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocols System, pp. 9-13.)

Family functioning, structure, and values have a significant impact on children's capacity to develop pro-social skills and cope with life's challenges. Parent and family skills training can provide parents and family members with new skills. These skills enable families to better nurture and protect their children, help children develop pro-social behaviors, and train families to deal with particularly challenging children.

This prevention approach addresses two clusters based on the risk levels of the target populations:

1. Families with children who are not known to have risk factors and families with children who are exposed to risk factors and are therefore at above-average risk. Common risks might include being in a single-parent family, a family in economic distress, or a family of divorce. [Universal or selective populations.]

2. Families with children who are at high risk because they are exposed to multiple risk factors or have a high level of exposure to a single risk factor. Examples might be children identified as having serious behavior problems, as being delinquent, as having substance-abusing parents, or as being victims of child abuse. [Indicated population.]

Because the activities and levels of evidence are unique to each cluster, they are presented separately below. The lessons learned and recommendations for practice that follow apply to both clusters.

CLUSTER 1

This cluster, as noted above, includes families with children who have no known risk factors. As noted earlier, according to the IOM's classification system, universal preventive measures are appropriate for these families. Cluster 1 also includes families with children who are exposed to risk factors and are therefore at above-average risk. Selective preventive measures are appropriate for these families.

The parent and family training activities or interventions in this cluster include some training sessions that involve the child and other family members and others that are parent oriented. All of the activities focus on changes in:

1. Parents – Acquiring or improving parenting skills, child management abilities, psychological helping skills, relationship development, and empathy

2. Families – Improving family cohesion, organization, relationships, and conflict resolution

3. Youth – Improving general child behavior, psychological adjustments, attachment to family, and commitment to school

Activities

1. Didactic presentations, both live and videotaped, followed by discussions

2. Role-playing and skills practice sessions

3. Curriculum-based training to recognize and modify risk and protective factors

4. Modeling sessions on interaction, communication, and crisis handling

5. Cognitive-behavioral workshops and multi-session training programs

CLUSTER 2

As noted above, this cluster includes families with children at high risk for substance abuse because they are exposed to multiple risks or have a high level of exposure to a single factor, such as conduct disorder. Indicated preventive measures are appropriate for these families (Institute of Medicine 1994).

The parent and family training activities or interventions examined in this cluster include parent training without child involvement, parent training with separate child training, family skills training, and parent training plus family skills training.

All of the activities focus on changes in:

1. Parents – Improving parents' attitudes toward their children, acquiring or improving parenting skills, child management abilities, problem-solving skills, communication skills, and crisis management abilities

2. Youth – Improving general behavior, acquiring or improving self-control and compliance, reducing antisocial and other problem behaviors, and reducing arrest rates

Activities

1. Videotaped modeling sessions, with and without counseling and practice

2. Manual-based training, with and without discussions

3. Didactic, role-playing, and skill practice sessions

4. Cognitive-behavioral and problem-solving skills training

5. Behavioral parent training

6. Parent and teacher training

7. Structural family therapy and family effectiveness training

8. Parent counseling

9. Individual and group therapy for parents, both with and without children

Risk Factors Addressed

Parental attitudes and involvement in drug abuse
Family management problems
Family conflict

Protective Factors Addressed

Skills
Bonding: Family

CSAP Strategy

Education
Information dissemination

Type of Strategy

Universal, Selective, or Indicated

Populations Appropriate for This Best Practice

Not defined

Evaluating This Best Practice

The following are suggested areas to assess when implementing this practice:

- Assess the level of communication between parent-child
- Assess family management skills
- Assess level of family conflict
- Assess level of family bonding

Research Conclusions

(Excerpt from *Family Centered Approaches*, Center for Substance Abuse Prevention, 1998, Prevention Evaluation Protocol System, p. 12.)

CLUSTER 1
For families with children who are not known to have risk factors and for families with children who are exposed to risk factors, the research and practice evidence reviewed indicates that it is possible to implement parent and family skills training interventions:

- There is strong evidence that these interventions can stabilize or improve the conditions that decrease risk factors for substance abuse, such as poor parent-child communication, child problem behavior, inadequate parenting skills, poor family relationships, parental substance use, family conflict, and family disorganization.
- There is suggestive but insufficient evidence that, when specifically directed, these interventions can improve children's social skills and pro-social behavior.
- There is suggestive but insufficient evidence that, when specifically directed, these interventions can reduce parental stress and depression, improve children's self-esteem, promote improvements related to differences in social assimilation between parents and children.
- There is suggestive but insufficient evidence that using a combination of parent training, children's social skills training, and family relationship training leads to greater improvements overall in parent-child relationships than would any of these interventions alone.

CLUSTER 2
For families with children who are at high risk for substance abuse because they either are exposed to multiple risk factors or have a high-level exposure to a single risk factor, such as conduct disorder, the research and practice evidence indicated that it is possible to implement parent and family training interventions:

- There is strong evidence that these interventions can decrease risk factors such as child problem behavior and poor parenting skills and increase protective factors such as healthy family communication, bonding, and conflict resolution.
- There is suggestive but insufficient evidence that these interventions reduce parents' stress, depression, and substance use; improve children's self-esteem; and promote improvements related to differences in social assimilation between parents and children.
- There is strong evidence that these interventions have a positive and lasting effect in improving parenting skills and behaviors as well as reducing diagnosed problem behaviors in children.

Note: The criteria used to rate the strength of evidence for each prevention approach are shown in Appendix A (of the source document).

Costs and Special Considerations

Not available

Contact Information

For more information, order a copy of CSAP's *Family Centered Approaches* from:

National Technical Information Systems

Phone: 800.553.6847

Practitioners guide cost: $29.50, order #PB 98159692
Reference guide cost: $58.00, order #PB 99101800

BEST PRACTICE: Parenting (Adolescents) Wisely

Description of Best Practice

(Excerpt from Strengthening America's Families' web site *http://www.strengtheningfamilies.org/index.html* and from Dr. Gordon)

Parenting Adolescents Wisely (PAW) is an interactive CD-ROM based program designed for families at-risk with children from early elementary to high school age. Video programs which overcome illiteracy barriers meet the needs of families who don't usually attend or finish parenting education. PAW seeks to help families enhance relationships and decrease conflict through behavior management and support. It enhances child adjustment and potentially reduces delinquency, substance abuse, and involvement with the juvenile justice system. In addition, PAW builds parental confidence in parenting skills. It seeks to improve communication, problem solving, and parent-school communication, while improving school attendance and grades and reducing disciplinary infractions.

Through a self-administered, self-paced CD-ROM program, parents view video scenes of common family problems. For each problem, parents choose a solution, see it enacted and listen to a critique.

The video program covers:
- communication skills
- problem solving skills
- speaking respectfully
- assertive discipline
- reinforcement
- chore compliance
- homework compliance
- supervising children who are hanging out with peers who are a bad influence
- step-family problems
- single parent issues
- violence, and others

The program is designed to be used by parents totally unfamiliar with computers, as well as those with computer experience. The program takes only one to two sessions lasting approximately three hours. Parents prefer using the program with their teens and pre-teens. Used as a family intervention, parents and children converse enthusiastically and learn the same skills together.

One staff member can deliver the program, which simply entails turning on the computer, booting the CD-ROM, and showing the parent(s) or parent and child how to move the mouse cursor on the screen. This procedure takes approximately two minutes and requires no skill, credentials, or training on the part of the staff member. Monitoring by the program developer is not necessary, but free telephone consultation is provided if needed.

Risk Factors Addressed

Early and persistent antisocial behavior
Family management problems

Protective Factors Addressed

Skill building – Parenting

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Families at-risk with children from early elementary to high school age
- Parents with illiteracy barriers

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
There is no cost for the tool. Please call the phone number in the "Contact" box below for data analysis costs to be negotiated with the developer.

The following are suggested areas to assess when implementing this practice:

- Assess change in family management skills
- Assess change in child behavior problems

Research Conclusions

(Excerpt from Strengthening America's Families' web site *http://www.strengtheningfamilies.org/index.html* and from Dr. Gordon)

A pre / post-test evaluation format was used which showed that parents had improved knowledge of parenting principles, use of appropriate parenting skills, and decreased child behavior problems. Almost half of the teens who scored in the clinically deviant range of the Eyberg Child Behavior Inventory had moved into the functional (normal) range of child behavior. A third evaluation showed the same kinds of changes as found in the first two studies, except the magnitude of changes in child behavior problems was greater. Problem behaviors had dropped to half of the previous rate one, three, and six months after the parents used the program. A control group showed no changes.

A fourth evaluation with teen parents found, relative to a control group, that the program produced significant improvements in parenting knowledge and application of principles to dealing effectively with toddlers. A fifth evaluation found that parents of problem middle school students reported 60% fewer problem behaviors four months after using the program, compared to a control group who reported no changes.

A sixth evaluation evaluated the program delivered via a laptop computer in the homes of severely disadvantaged families. Parents and their 4th to 6th graders reported im-

proved family relationships and lower family risk factors for delinquency and substance abuse relative to a comparison group reading parenting brochures. Both groups reported improvements in child problem behavior, with the CD-ROM group reporting more changes.

A seventh evaluation comparing delivery formats for the CD-ROM indicated there may be more improvements in child problem behavior when the program was used in groups than individually. An eighth evaluation with high school students who received either the CD-ROM in group format or the usual parent education classes found improvements in knowledge of parenting principles and skills only for the CD-ROM group, when the program was used in groups than individually.

Costs as of December 2001 (Subject to Change)

Note: Training is optional and is primarily motivational to encourage community service providers to use the Parenting Wisely program. The PW program is self-administered, therefore professionals do not need training in its use.

Training Time:
4 - 8 hours depending upon group size and experience

Training Cost:
$2,000 for a one-day training, plus $1,000 additional fee if travel time is greater than a half day, and per diem. An associate (doctoral student) one-day training is $1,000 plus travel and per diem.

Strategy Implementation:
$2,450 for 100 participants plus

$1,700 if a desktop computer and laptop computer must be purchased

$2,000 ($20 per family) for incentives to increase parental cooperation for high risk families (optional)

The $2,450 figure includes the following:
- Two CD-ROM kits (one American English and one Spanish, or one American English and one British English)
- One videotape series
- 100 Parent workbooks

This CD-ROM program comes with a kit. The kit includes:
- A manual for community implementation
- Five parent workbooks
- Program completion certificates
- Program brochures
- Referral cards
- Poster
- Brief motivational video for parents
- A floppy disk containing evaluation forms and evaluation instructions

The program is also available in Spanish, at the same price, and quantity discounts are available for multiple kits. There is also a British version of the program, with a different design and different actors, to be used when parents repeat the program. The program is also available in an abbreviated and non-interactive form on a set of three videotapes that can be used as a booster for in-home use after the family has used the CD-ROM.

Special Considerations

Please consider the following before selecting this strategy for your community:
- Reading level of program is 5th grade, but for illiterate parents the program text can be read aloud by the program itself.
- The best locations for program implementation are at accessible social service agencies, schools, or public libraries.
- To reach the most resistant parents, we recommend home delivery of the program via a laptop computer. In this way, several family members can use the program together, increasing the interaction and possibly the benefit of the program.
- The program developers and others have had much success calling at-risk families and offering them $20 for feedback about their views of the program. They offer to bring the program to their home, and present this approach similar to a marketing survey. In this way, parents do not feel singled out or blamed.

Contact Information

For materials, ordering, or for training information, contact:

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Phone: 740.593.9505 (EST) or
541.201.7680 (PST)
Fax: 740.593.0186
Web site: *http://www.familyworksinc.com* or
www.parentingwisely.com

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BEST PRACTICE: Parenting and Family Skills Program: Helping the Noncompliant Child

Description of Best Practice

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 58-60.)

Program Objectives
Primary goals are secondary prevention of serious conduct disorder problems in preschool and early elementary school-aged children, and the primary prevention of subsequent juvenile delinquency. Short-term and intermediate objectives include:

a) Disruption of coercive parent-child interactions and the establishment of positive, pro-social interactions

b) Improved parenting skills in tracking the child's positive behaviors, increased use of praise and positive statements, ignoring of minor inappropriate behaviors, provision of clear and appropriate instructions, and provision of appropriate consequences for compliance, noncompliance, and other behaviors

c) Increased child pro-social behaviors and decreased conduct problems.

Program Strategies
The parent training program focuses on teaching parents to change maladaptive patterns of interaction with their children. The 60 to 90 minute sessions are conducted in a clinic setting with individual families rather than in groups. In an ideal setting, sessions occur in clinic playrooms equipped with one-way mirrors for observation, sound systems, and sound devices by which the therapist can communicate unobtrusively with the parent; however, these are not necessary for the successful implementation of the program.

This active program places a great deal of emphasis on helping the parent become competent and comfortable with the various parenting skills taught in the program. Progression to each new parenting skill in the program is based on the competent performance of the earlier skills. This facilitates individualization of the treatment program by allocating training time more efficiently, since the therapist can focus attention on more serious parenting skill difficulties.

The number of sessions needed for completion of each phase of treatment depends on the speed with which the parent demonstrates competence and the child's response to treatment. The average number of sessions is 10-12. Sessions are typically held once or twice weekly.

Staffing
A single family therapist is all that is necessary to conduct the program successfully. However, if resources permit, use of a co-therapist can increase the therapist's flexibility in demonstrating various skills to the parent (e.g., the therapist and co-therapist may demonstrate these by role-playing the parent and child).

Resources Needed and Materials Available
A comprehensive presentation of the program is contained in the therapist's manual (Forehand & McMahon, 1981). Parents are provided handouts specific to each skill for reference in the home setting, are assigned homework to practice their newly acquired skills, and are given data sheets to record their results.

Special Characteristics
This social-learning based program consists of two phases. Phase I (the differential attention phase) helps the parent to use positive verbal and physical attention contingent upon compliance and other appropriate behaviors, and to ignore minor inappropriate behavior. Phase II teaches the parent to use clear instructions and to provide appropriate consequence for child compliance and noncompliance. The parent learns to issue instructions one at a time that are clear, concise, and direct, and to allow the child sufficient time to comply. The parent is taught to praise or attend to the child within 5 seconds of compliance initiation. A time-out procedure is used when the child is noncompliant. Standing rules are designed and implemented for each child.

Comments on Implementation/Replication
As with other programs that require a trained therapist, the costs of this program may make it difficult for some agencies to implement.

Risk Factors Addressed

Early antisocial behavior

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Parents and their three- to eight-year-old children who are exhibiting noncompliance and other conduct problems, such as attention-deficit hyperactivity disorder
- Mothers at risk of child abuse and neglect
- Parents of children with handicaps

Evaluating This Best Practice

This best practice does not come with an evaluation tool that can be used when implementing this strategy.

The following are suggested areas to assess when implementing this practice:

- Assess decrease in conduct problem behaviors such as

aggression, tantrums, destructiveness, and inappropriate verbal behavior.

- Assess improvements in child compliance

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention*, Office of Juvenile Justice and Delinquency Prevention, 1993, pp. 59-60.)

This parent training program has been extensively evaluated (see McMahon & Forehand, 1984).

- Parent and child behaviors have been shown to improve in the home to within the normal range as a function of treatment as have parents' perceptions of their child's adjustment. Furthermore, these improvements occur regardless of the families' socioeconomic status (although families from lower socioeconomic backgrounds are less likely to complete the program) or age of the children (within the three to eight year-old range).
- Improvement in child compliance has been shown to be accompanied by decreases in other conduct problem behaviors such as aggression, tantrums, destructiveness, and inappropriate verbal behavior.
- Maintenance of effects has been demonstrated in a series of studies with follow-up assessments ranging from six months to more than 14 years after treatment termination.

Parents have also indicated high levels of satisfaction with the parent training program. The parent training program has also been successfully employed with other high-risk populations, including:

- Children with handicaps (Hanf & Kling, 1973)
- Those with attention-deficit hyperactivity disorder (Pisterman, Mcgrath, Firestone, Goodman, Webster, & Mallory, 1989)
- Mothers at risk of child abuse and neglect (Wolfe, Edwards, Manion, & Koverola, 1988)
- And as a component of a preventative intervention for children of alcohol and drug abusing parents (Kumpfer & Demarsh, 1987)

Costs as of December 2001 (Subject to Change)

Training Time: Two days

Training Cost: $3,000 ($1,500 / day plus expenses)

Note: Training is not required but highly recommended. There are qualified trainers in most areas of the country. On-site practice and follow-up supervision have been found to be extremely helpful in implementing this program. Additional consultation and technical assistance are available and are usually negotiated on an individual basis. There is no minimum number of training participants; however, there is a ceiling of 16-20 participants in a training session. The trainer's manual, training videotape, and self-help book for parents must be purchased separately. A new trainer's manual (McMahon & Forehand, 2001) will be published in 2003.

Special Considerations

None specified by the authors of this program

Contact Information

For inquiries about training, technical assistance, materials, or for more information contact:

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BEST PRACTICE: Parenting Skills Program

Description of Best Practice

(Excerpt from materials provided by Parenting Skills Program staff in January 2002.)

Program Origin
The Parenting Skills Program for problem prevention and enrichment was developed in the mid and late 1970s. It is an offshoot of the Filial (parent-child) Therapy program that has been actively employed since the early 1960s. The therapy program is the work of Bernard Guerney, Ph.D. The adaptation for training birth, adoptive, and foster parents for non-therapeutic application was developed by Louise Guerney, Ph.D. The Guerneys are both Professors Emeritus from Pennsylvania State University, where the development, application, and research were done on these programs.

Program Objectives
Primary program objectives are to teach parents communication skills and child management skills that will result in improved parent-child relationships and foster good psychosocial adjustment in the children. Parent use of these skills is related to freedom from drug and alcohol abuse, delinquency, teen-aged pregnancy, and school dropout. Improved academic performance and pro-social skills are expected.

Program Strategies
Training techniques include minimal readings and homework assignments, mini-lectures, skills training, and practice with feedback. The emphasis is on skills acquisition and practice but discussion for processing the skills is built into the lessons. There is much flexibility in the program format. It can be offered to a single parent, a single family, or a group of parents. Typical groups are 12 to 16 parents in number with one or two leaders.

The most commonly used format is eight lessons but six- and ten-week formats are also laid out in the leader's manual for use when time is short or when ten weeks are possible. The number of skills is not reduced in the six-week format but the amount of time for practice and discussion must be reduced. Nonetheless, parents taking the six-week course show positive pre-post gains. The ten-week format allows either extra skills practice or extra discussion lessons on topics pertinent to the group or family, e.g., parenting children with special needs. The eight-week format requires 16 hours to cover which may be offered in two-hour weekly sessions, in a weekend, or in daylong sessions. Times can be tailored to meet the requirements of the parents.

Staffing
No special educational or professional background is required. Most frequent leaders are prevention specialists, Head Start staff, social workers, and counselors, but anyone properly trained to use the program may offer it. Training is provided through a non-profit institute, IDEALS (Institute of the Development of Emotional and Life Skills).

Certification as a trainer and a trainer supervisor is available. IDEALS trainers travel throughout the United States and Canada. Training fees include a daily fee plus travel and per diem expenses. Usually 12 enrollees for leadership training are necessary to make the per-trainee cost reasonable. Follow-up supervision is available via audio or videotape and telephone if the training site is distant from IDEALS' location in Bethesda, Maryland. Certification requires follow-up supervision.

Resources Needed and Materials Available
Leaders' and parents' manuals are available and a videotape with vignettes of children presenting parenting dilemmas for parents to respond to.

Risk Factors Addressed

Family management problems

Protective Factors Addressed

Bonding: Family

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal
Selective

Populations Appropriate for This Best Practice

- Foster parents
- Parents of low socioeconomic status
- Parents of varying religious backgrounds
- Parents from inner-city and rural areas

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost: $5.00 per form
This includes scoring information and explanations of the administration. The forms may be duplicated without charge as long as the measure is properly identified and source cited.

The measure is ten pages long and has two equivalent forms — one to be used for the pre-test and one for the post-test. The questions are multiple choice and center around parent-child dilemmas. They are intended to measure whether the parents mastered the skills taught. They do not measure changed attitudes or behaviors. For the latter, standard measures such as the Parenting Stress Index (Richard Albin) have been used.

The following suggestion is an area you may want to assess if you implement this best practice:

- Assess the increase in family management skills

Research Conclusions

(Excerpt from *Strengthening America's Families: Promising Parenting Strategies for Delinquency Prevention,* Office of Juvenile Justice and Delinquency Prevention, 1993, p. 39.)

The program has been very thoroughly investigated in its foster parent form. In relation to foster parents, parental acceptance and parenting skills improve significantly on pre-post tests. FPSTP outcomes were significantly higher for both parents and their foster children than the outcomes of a control group. These significant changes in parent attitudes, skills acquisition, and caseworker evaluation of family and children continued over a period of five years for six waves of parent trainees. Trainers taught to offer the program showed positive changes in relation to their own skill use and job performance. (Three reports from IDEALS are available on these results.)

In relation to the infant version, parents in the local Childbirth Education Association, trained to conduct the program, were able to bring about significant pre-post changes in parents of babies six months and younger in age. These results were significantly more positive than a comparable new mother-support / discussion group offered during the same pre-post period.

Costs as of January 2002 (Subject to Change)

Preferred Training Time:
21 hours to train parent leaders. This includes three hours supervision while offering the course for the first time.

Optional Training Time:
Two very intensive eight-hour days. Additional follow-up supervision would be recommended.

Training Cost:
$1,200 per day for the primary trainer. If the number of trainees is large, e.g., if a few agencies combine for the training, a second trainer or even a third would be required to provide the small group practice needed for conducting mock group sessions with trainees role-playing difficult and challenging parents playing the roles that parents are known to do in real training sessions. Issues of recruitment, retention, and cooperation with community resources are also covered. Additional trainers would be paid the same fee as the primary trainer. Travel and per diem expenses would be paid to trainers in addition to the training fees.

Strategy Implementation Cost:
Required would be manuals for the parent leaders at $24.95 each and manuals for the parents who will participate. These cost $9.95 each with a 40% discount for bulk purchases, i.e., 12 or more. Adolescent supplement manuals are needed if the target population is primarily adolescents and / or adolescents are a secondary issue for participating parents. These cost $9.00 each. Leaders' manuals are not available until leaders have actually enrolled in the leadership training program. Parent manuals may be purchased at any time. Optional is the videotape with the vignettes mentioned above. This is $79.95 plus shipping and handling, and is purchased from the Pennsylvania State University Audio-Visual Service, University Park, PA 16802.

Additional Cost:
Reproduction costs for parents' program feedback form and information handouts for parents. Supervision costs would be additional and would depend on whether supervision was by phone or on-site.

Special Considerations

Please consider the following before selecting this strategy for your community:

- The parent's manual is at a sixth-grade reading level that makes it quite manageable for most parents.
- It is best to implement the program in a place where parents are comfortable, e.g., a day care center, Head Start Center, or local church.
- Parent educators must have time available among their other duties to master the offering of the course and give it on a predictable basis. The practice can be truly preventive in that taking it before parent-child problems require treatment can divert the family from the treatment route. This frees up agency staff to provide treatment to fewer parents.

Contact Information

For information on training or materials, contact:

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BEST PRACTICE: Parents As Teachers

Description of Best Practice

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html* with modification by Parents As Teachers staff on August 2, 2001.)

Parents as Teachers (PAT) is an international family education and support program that begins prenatally–the onset of learning–and extends to kindergarten entry. Acknowledging that parents are the first and most influential teachers of their children, the program's primary goal is to help families lay a strong foundation for children's success in school and in life. PAT provides appropriate ways parents can stimulate their children's intellectual, language, social, and motor skills, thus enhancing parent-child interaction and strengthening family relationships. The program provides screening of children for early detection of developmental, health, hearing and vision problems, and helps communities by building a strong partnership between parents and schools. The program meets the needs of broadly diverse families, cultures and special populations including teen parents, parents of children with special needs, families facing critical issues, families living on American Indian reservations, families who are homeless and formerly homeless, and those living on military bases. The program is also adapted for center-based providers.

The program provides the following services:

1) Personal visits– PAT-certified parent educators, help parents understand and have appropriate expectations for each stage of their child's development
2) They use the Born to Learn™ Curriculum to bring the latest neuroscience research findings to parents, offering practical ideas on ways to encourage learning and interact with their children
3) Group meetings– parents meet to enhance their parenting knowledge, gain new insights and share their experiences, common concerns and successes
4) Developmental screenings– Parents as Teachers offers periodic screening of overall development, health, hearing, and vision to provide early detection of potential problems and prevent later difficulties in school and
5) Linkage to a resource network– families are helped to access other needed community services that are beyond the scope of the PAT program.

Risk Factors Addressed

Academic failure beginning in late elementary school

Protective Factors Addressed

Bonding – Family
Skills – Parenting

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

Parents with children ages 0-5

Evaluating This Best Practice

This best practice does not currently come with an evaluation tool that can be used when implementing this strategy. However, an evaluation tool is currently being developed.

The following are suggestions of areas you may want to assess if you implement this best practice:

- Assess the language, social development, problem solving, and other cognitive abilities of the PAT children
- Assess the results of kindergarten readiness tests of the PAT children
- Assess the results of standardized measures of achievement in early grades of the PAT children
- Assess PAT families' rates of suspected or documented incidents of child abuse and neglect
- Assess results of PAT screenings and referrals to track vision, hearing, and overall development
- Assess changes in PAT parents' knowledge of child development, parenting attitudes, and parenting behavior with a focus on parent/child reading behavior, home literacy, literacy promoting behaviors, and quality of parent/child interaction
- Assess PAT parents' involvement in their children's schools

Research Conclusions

(Excerpt from Parents as Teachers' web site, *http://www.patnc.org/researchevaluation.asp*)

Independent evaluations continue to confirm the positive impact of PAT on both parents and children:

Child outcomes

- PAT children at age 3 are significantly more advanced in language, problem solving and other cognitive abilities, and social development than comparison children.
- The positive impact on PAT children carries into elementary school.
- PAT children score higher on kindergarten readiness tests and on standardized measures of reading, math and language in first through fourth grades.

Parent and family outcomes

- PAT parents are more involved in their children's schooling.
- PAT parents are more confident in their parenting skills and knowledge.

- PAT families have lower rates of suspected or documented incidents of child abuse and neglect than comparison groups or state averages.

Cost as of December 2001 (Subject to Change)

Training Time:
5 days plus one day of technical assistance

Training Cost:
- Cost to attend the Born to Learn™ Institute runs from $475 to $625 per participant depending on location of the training. A sixth day of technical assistance within six months of the institute is included in this price.
- Supervisors of parent educators are required to attend the first two days of the Born to Learn™ Institute at a cost of $25. Specialized trainings are also available.
- If your program serves teen parents, families facing critical issues or have children with special needs there are additional two-day trainings available that range in price from $240 to $365.
- Cost to attend the two-day 3 to 5 Training is $265-$340 depending on the location. (Prices include the cost of curriculum.)

Implementation Cost:
In order to implement a Parents as Teachers program, there must be established funding and a supervisor with at least one parent educator. Each parent educator must attend the complete Institute, pass the daily assessments, and submit an approved implementation plan. The major cost of implementing a PAT program is the salary and travel of the parent educators. Most PAT parent educators, on average, are paid $17 an hour depending on location of the program. Many work part-time (20 hours a week), serving 20 families with monthly visits and additional visits where needed. Some programs hire parent educators on a full-time basis. Total costs for programs including facility charges, program materials such as activities and books, and annual recertification fees ($35 per parent educator) depend on the amount of in-kind donations of the sponsoring organization. PAT parent educators use, and encourage families to use, resources that are readily available in the home for parent-child activities.

A program purchases a set of Born to Learn™ Curriculum materials (two modules and a 16-segment video series) for every parent educator. The curriculum costs $275 and belongs to the program. One Program Administration Guide must also be purchased by each program at a cost of $25. All these materials are copyrighted by the Parents as Teachers National Center, Inc., and are to be used in certified PAT programs only.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- Sustainable funding is needed to support Parents As Teachers over time.
- Collaboration of groups in the community is essential, including Head Start, the school district, and other early childhood programs.
- All four components of the program need to be implemented, including home visiting, health and developmental screenings, group meetings, and linkages to resources.
- An implementation plan has to be submitted prior to implementing Parents as Teachers.

Contact Information

For more information on this program, visit:
Web site: *http://www.patnc.org*

For more information, contact:
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Fax: 314.432.8963

For information about training, contact:
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BEST PRACTICE: Parents Who Care

Description of Best Practice

(Excerpt from Strengthening America's Families' web site *http://www.strengtheningfamilies.org/index.html*, updated by Channing Bete Company in December 2001.)

Parents Who Care (PWC) is an educational skill-building program created for families with children between the ages of 12-16. PWC, developed by David Hawkins, Ph.D., and Richard Catalano, Ph.D., is an extension of Preparing for the Drug Free Years. The objective of PWC is to reduce risk factors and strengthen protective factors that are know to predict later alcohol and other drug use, delinquency, violent behavior, and other behavioral problems in adolescence. The PWC program is grounded theoretically in the social development model which emphasizes that young people should experience opportunities for active involvement in family, school, and community, should develop skills for success, and should be given recognition and reinforcement for positive effort and improvement. PWC focuses on strengthening family bonds and establishing clear standards for behavior, helping parents more appropriately manage their teenager's behavior while encouraging their adolescent's growth toward independence. In this process, PWC seeks to change specific risk and protective factors for problem behaviors in the family and peer domains: parent and sibling drug use, positive parental attitudes towards drug use, poor and inconsistent family management practices, family conflict, low family communication and involvement, family bonding, and association with delinquent and drug using peers behaviors.

The program is designed to be led by a facilitator and taught once a week in 5 to 6 sessions lasting 1-2 hours. The program is very flexible and can be facilitated through schools, healthcare organizations, civic organizations, social service organizations, and faith institutions. Parents that attend the workshops are provided with their own parent module for use at home. The PWC book consists of seven chapters and corresponding video segments. The video follows four ethnically diverse families as they struggle with the issues and emotions that many parents confront.

The program is structured around three major topics:

1) setting the stage, which covers the importance of risk and protective factors
2) the power of communication, and
3) family management

Risk Factors Addressed

Family management problems
Parental attitudes favorable towards drugs, crime and violence
Antisocial behavior

Protective Factors Addressed

Bonding – Family
Skills – Parenting

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal
Selective

Populations Appropriate For This Best Practice

Families with adolescents ages 12-16 who are at risk for developing problems with alcohol, drug use or delinquency

Evaluating This Best Practice

This best practice comes with a pre-post test evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
Included in the cost of the curriculum. However, the tool must be requested, as it is not routinely included with the curriculum.

The following are suggestions of areas you may want to assess if you implement this best practice. (For assistance on creating an evaluation plan, refer to Step 7: Evaluation.)

- Assess the family management skills of participating parents.
- Assess participating parents' attitudes towards drugs, crime and violence.
- Assess the occurrence of antisocial behavior in youth of participating parents.

Research Conclusions

(Excerpt from Strengthening America's Families' web site, *http://www.strengtheningfamilies.org/index.html* updated by Channing Bete Company in December 2001.)

An experimental evaluation was conducted with 66 families with adolescents ages 12 to 16. The families were self-identified as having adolescents who were at risk for developing problems with alcohol, drug use, or delinquency. The research design was a pre-test post-test design with random assignment to either a treatment (n = 35) or wait-list control group (n = 31). Analyses revealed significant differences in risk and protective factors targeted by the intervention at post-test between the two groups. Results for parent participants indicated that the treatment group showed a statistically significant improvement in three areas: 1) family discipline, 2) family attitudes favorable to antisocial behavior, and 3) level of family bonding. The treatment group

at post test also showed lower levels of risk factors of poor family supervision and low parental commitment to school. Overall, the initial evaluation shows promise for changing family-focused risk and protective factors.

Costs as of December 2001 (Subject to Change)

Training Time and Cost:
No training is necessary to implement this program. However, if desired, technical assistance is available.

Implementation Cost:
To conduct a PWC parent group, only one discussion leader is needed who has facilitation experience and who is familiar with the basic elements of learning theory and its application to both adolescents and adult learning. The facilitator should be familiar with the content of PWC and be able to adapt the program to fit specific community needs.

The program package contains everything needed to hold the parent discussion groups including one Facilitator's Manual complete with video and workbook, activities, blackline masters, discussion questions, resources and ten parent modules for $1,200.00. Additional facilitator and parent modules are available at $299.00 and $99.00, respectively. To encourage parent participation, transportation to the location should be considered and childcare would be beneficial for younger children accompanying the parents. Also, providing the individual parent modules at no cost or at a nominal fee would be helpful.

Special Considerations

The following should be taken into consideration before selecting this strategy to be implemented in your community:

- The age of youth included in this program is typically 12-16. It is not recommended for use with youth younger than 13 or older than 18.
- This curriculum is available in Spanish.

Contact Information

For general information, contact:

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For training and materials, contact:

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BEST PRACTICE: Perry Preschool Project – High/Scope Approach

Description of Best Practice

(Information provided by Gavin Haque of High Scope Education Research Foundation, June 28, 2001.)

The High/Scope Approach is utilized in thousands of infant/toddler, early childhood, elementary, and adolescent programs around the world. The approach, based on the work of Jean Piaget and other constructivists, calls for teachers sharing control with their students while providing exciting classroom experiences based on children's strengths, needs, and interests.

Research from the High/Scope Perry Preschool study indicates that such an intervention program promotes the general welfare of students and their families through greater employment opportunities, lower participation in welfare programs, lower teenage pregnancy rates, and a decrease in violent crime.

The High/Scope Approach can be implemented in many types of settings: center-based, home-based, and shared environments. Successful programs that implement High/Scope's approach share the following characteristics:

- A developmentally appropriate curriculum that views children as active, self-initiated learners.
- Small classrooms of 20 children and at least two staff who allow a more supervised and supportive learning environment.
- Staff who are trained in early childhood development and education, who receive supervision and on-going instruction, and who actively communicate with parents.
- Sensitivity to the non-educational needs of disadvantaged children and their families, which includes providing meals and recommending other social service agencies.
- Ongoing monitoring and evaluation of both teachers' activities and children's behaviors and development.

Risk Factors Addressed

Early and persistent antisocial behavior
Academic failure
Low commitment to school
Economic deprivation

Protective Factors Addressed

Skills: Academic
Bonding: School

CSAP Strategy

Education

Type of Strategy

Selective

Populations Appropriate for This Best Practice

- Low socioeconomic families
- African Americans

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The High/Scope Child Observation Record (COR) provides an opportunity to track children's development throughout the program year. For a cost of $90.95, teachers can assess a classroom of twenty-five students on three occasions. Additionally, the High/Scope Program Quality Assessment (PQA) allows teachers to critique the effectiveness of their programs and make modifications based on the elements of quality- Active Learning, Adult/Child Interaction, Learning Environment, and Parent Involvement.

The following are suggested areas to assess when implementing this practice:

- Assess antisocial behavior and misconduct of participants
- Assess academic achievement, including grades and scores on standardized tests
- Assess commitment to school, including attitudes toward school

Research Conclusions

(Excerpt reprinted with permission from the Center for the Study and Prevention of Violence, Institute of Behavioral Science, Regents of the University of Colorado, *http://www.Colorado.EDU/cspv/blueprints/promise/perPre.htm*)

Evaluations have demonstrated a wide range of successful outcomes for children who participate in programs that use High/Scope teaching strategies, compared to those who did not receive intervention, including:

- Less delinquency, including less contact with juvenile justice officials, fewer arrests at age 19, and less involvement in serious fights, gang fights, causing injuries, and police contact
- Less antisocial behavior and misconduct during elementary school and at age 15
- Higher academic achievement, including higher scores on standardized tests of intellectual ability and higher school grades
- Fewer school dropouts at age 19 (33% vs. 51%) and higher rates of high school graduation
- Greater commitment to school and more favorable attitudes about high school
- Higher rates of employment (50% vs. 32%) and pay, and greater job satisfaction
- Greater economic independence and less reliance on public assistance, including welfare usage
- Fewer pregnancies and births for women at age 19

Costs as of May 2001 (Subject to Change)

Training Time: Varies

Training Cost:
$2,850 per person; training costs vary by group size. The rate given is for 20 people, 4 weeks of training at 30 hours per week.)

Strategy Implementation:
The program costs $57,000 for 20 participants.

Special Considerations

Please consider the following before selecting this strategy for your community:

- The High/Scope curriculum framework has proven effectiveness in preventing school failure, dropout, and crime with disadvantaged children.

Contact Information

For training, technical assistance, and materials contact:

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BEST PRACTICE: Preparing for the Drug Free Years

(Hawkins and Catalano)

Description of Best Practice

(Excerpt from materials provided by Channing Bete Company in December 2001.)

Preparing for the Drug Free Years (PDFY) is a multimedia program developed by David Hawkins, Ph.D., and Richard Catalano, Ph.D., which provides parents of children in 4th through 8th grades the knowledge and skills they need to guide their children through early adolescence. The program aims to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and resist drug use.

Over the last 20 years, research has shown that positive parental involvement is an important protective factor that:

- Increases school success
- Buffers children against later problems such as substance abuse, violence, and risky sexual behaviors

PDFY is made up of the following components:

- A Workshop Leader's Guide, which includes masters for parent handouts
- A Family Guide
- A videotape with five vignettes (one for each parent session)
- A complete set of transparencies on CD

A PDFY workshop kit contains:

- Two Workshop Leader's Guides with CD
- Two videos
- One Family Guide (A Family Guide is needed for each participating family.)

The program is comprised of five two-hour sessions usually held over five consecutive weeks. Curriculum can also be presented in ten one-hour sessions. The sessions are interactive and skill based, with opportunities for parents to practice new skills and receive feedback from workshop leaders and their parent peers. Video-based vignettes demonstrate parenting skills through the portrayal of a variety of family situations. Families are provided with a Family Guide containing family activities and discussion topics, as well as skill-building exercises and information on positive parenting.

Session topics include:

- How to Prevent Drug Abuse in Your Family
- Setting Clear Family Expectations on Drugs & Alcohol
- Avoiding Trouble
- Managing Family Conflict
- Strengthening Family Bonds

The program has been offered to parents in schools, worksites, churches, community centers, homes, hospitals, and prisons.

Risk Factors Addressed

Family management problems
Family conflict
Favorable attitudes toward drug use
Parental attitudes and involvement
Friends who use
Early initiation of substance abuse

Protective Factors Addressed

Bonding: Family
Opportunities, skills, and recognition
Healthy beliefs / clear standards

CSAP Strategy

Information dissemination
Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Parents of children in grades 4 - 8 (ages 9 - 14)
- Urban, multi-ethnic communities
- African American
- Native American
- Hispanic / Latino
- Asian / Pacific Islander
- Caucasian

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy. The tool is available upon request and includes a pre- and post-written test.

Evaluation Tool Cost:
There is no cost for this tool.

The following are suggested areas to assess when implementing this practice:

- Assess increased parenting skills
- Assess increased family bonding

Research Conclusions

(Excerpt from Channing Bete Company in December 2001.)

- Significant effects on targeted parenting behaviors were found at post-test and maintained one year later. Results of dissemination studies showed increased parental knowledge about the family's role in prevention, unfavorable parental attitudes towards drug use, and increased use of family meetings to prevent drug use in children.

- At the two-year follow-up, youth in the PDFY group who had not initiated substance use at the one-year follow-up were significantly more likely to have remained non-users by the two-year follow-up than their counterparts in the control group. Youth in the PDFY group who had initiated substance use at the one-year follow-up were significantly less likely than youth in the control group to have progressed to more frequent or varied drug use by the two-year follow-up.
- At the 3.5 year follow-up, youth in the PDFY group had significantly lower growth in initiation rates for drunkenness and marijuana use than the youth in the control group. The PDFY group also had a significantly lower proportion of youth who reported using alcohol during the previous month, lower frequencies of alcohol use, and lower growth of alcohol use frequency.
- Further analyses showed youth in the PDFY group had significantly less growth in alcohol use (a combined measure of initiation, frequency, and defying parent's alcohol rules), and significantly higher parental norms against alcohol and other drug use than the control group three and one-half years after the intervention (Park, Kosterman, Hawkins, Haggerty, Duncan, Duncan & Spoth, 2000).

Costs as of December 2001 (Subject to Change)

Training Time: Three days

Training Cost:
$4,500 plus $100 per participant up to 12 participants, plus travel costs for one trainer

Strategy Implementation:
$695 plus shipping for the curriculum kit that is purchased separately. The kit includes training materials for two workshop leaders to train parents. Volume discounts are available for the purchase of the Family Guide.

Special Considerations

Please consider the following before selecting this strategy for your community:

- This parent education program is for parents of children in grades 4 – 7

Contact Information

For general information, contact:

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BEST PRACTICE: Project ACHIEVE

Description of Best Practice

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 59-60.)

Project ACHIEVE is an innovative school reform program developed for use in elementary and middle schools (students 6 to 14 years old). It is designed to help schools, communities, and families develop, strengthen, and solidify their youths' resilience, protective factors, and self-management skills. Project ACHIEVE works to improve school and staff effectiveness, and places particular emphasis on increasing student performance in the areas of: (a) social skills and social-emotional development; (b) conflict resolution and self-management; (c) achievement and academic progress; and (d) positive school climate and safe school practices.

Objectives

- Enhance the problem-solving skills of teachers such that effective interventions for social (in particular violence) and academic difficulties of at-risk students are developed and implemented.
- Improve the building and classroom management skills of school personnel and the behavior of students to create a disciplined environment within which to learn through the use of a building-based social skills and aggression control training program.
- Improve the school's comprehensive services to students with below-average academic performance such that they are served, as much as possible, in the regular classroom setting and have equal access to high-quality educational programs.
- Increase the social and academic progress of students through enhanced involvement of parents and the community in the education of their children.
- Create a school climate in which each teacher, staff member, and parent believes that everyone is responsible for every student in the school building and community.

Intervention

Project ACHIEVE is implemented in a series of sequenced steps over a three-year period. Before implementation, a detailed overview is provided to the entire school staff, and an 80 percent acceptance vote is required to implement the program. Once accepted, an organizational analysis and needs assessment is completed, a pupil personnel support team is identified, and pre-project baseline data is collected.

Project ACHIEVE's components include the following:

- Strategic planning and organizational analysis and development.
- Referral Question Consultation (RQC) problem solving process
- Effective classroom and school processes / staff development
- Instructional consultations and curriculum-based assessment and intervention
- Social skills, behavioral consultation, behavioral interventions, and school safety
- Parent training, tutoring, and support
- Research, data management, and accountability

Training is facilitated by pupil services personnel and involves regular and special education teachers, bus drivers, school staff (custodial, cafeteria, office) parents, and volunteers. A "training of trainers" model is also used.

Risk Factors Addressed

Academic failure
Lack of commitment to school

Protective Factors Addressed

Skills: Problem solving, social skills, anger-reduction techniques
Bonding: School

CSAP Strategy

Education
Environmental

Type of Strategy

Universal
Selective

Populations Appropriate for This Best Practice

- Academically and socially at-risk, and underachieving students
- Pre-K through middle school settings
- African American and Caucasian students

Evaluating This Best Practice

This best practice comes with an evaluation process and sample protocols / tools that can be used when implementing this strategy.

Evaluation Tool Cost:

There is no cost for these, however at times schools and districts are referred to places that have created software and web sites with evaluation tools and programs. Some of these have additional costs associated with them.

The following are suggested areas to assess when implementing this practice:

- Assess the rate of referrals to and placements in special education.
- Assess the rate of disciplinary referrals to the principal's office.

- Assess the increase in the number of students scoring above the 50th percentile on end-of-year achievement tests.
- Assess an improvement in teachers' perceptions of school climate.
- Assess the rate of student grade retentions.
- Assess the rate of out-of-school suspensions.

Research Conclusions

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 59-60.)

Since its creation in August 1990, the project has achieved the following:

- 75% decrease in student referrals to special education
- 67% decrease in student placements in special education
- 28% decline in total disciplinary referrals to the principal's office
- A decline in student grade retentions from 6 percent of the total student population to .006.
- An increase in the number of students scoring above the 50th percentile on end-of-year achievement tests.
- An improvement in teachers' perceptions of school climate.
- Academic improvements for those students whose parents were trained in the Parent Drop-In Center.

Costs as of December 2001 (Subject to Change)

Training Time:
Two workshop days, plus one day of on-site technical consultation

Training Cost:
$1,500 / day plus travel and other expenses

Note: The training goal is to help schools to develop a comprehensive, building-wide discipline, behavior management, and school-safety system with procedures and strategies that focus on prevention, strategic intervention (when needed), and wrap-around approaches for intensive need students.

Strategy Implementation:
Approximately $8,500 for a three-day in-service, plus technical support and program materials.

This figure includes the following:
- $4,500: Three-day honorarium
- $1,500 (estimate): Transportation
- $2,000: Social-skill teacher manuals / posters / signs / support material
- $500: Workshop handout duplication costs

Special Considerations

Please consider the following before selecting this strategy for your community:

- This is a school-wide effort and consultation / professional development process. Schools will need to demonstrate (through questionnaire responses) the organizational readiness and staff motivational readiness (through a vote prior to consultation) of the school.

Contact Information

For more information on this program, visit web sites:
http://modelprograms.samhsa.gov and
http://www.coedu.usf.edu/projectachieve

For training, materials and technical assistance contact:
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Additional references:

Knoff, H. M. (2002). Best practices in organizational assessment and strategic planning. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology-IV.* Bethesda, MD: National Association of School Psychologists.

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Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). *Safe, drug-free, and effective schools for ALL children: What Works!* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

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BEST PRACTICE: Project ALERT

Description of Best Practice

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 61-62.)

Project ALERT is a school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets cigarettes, alcohol, and marijuana use.

Objectives
To enable students to do the following:

- Develop reasons not to use drugs
- Identify pressures to use them
- Counter pro-drug messages
- Learn how to say no to external and internal pressures
- Understand that most people do not use drugs
- Recognize the benefits of resistance

Intervention
Project ALERT is a video-based curriculum designed for sixth and seventh grade, or seventh and eighth grade, students. The first year's program consists of eight lessons, taught a week apart. These lessons are reinforced during three additional lessons in Year 2. The highly participatory curriculum makes extensive use of question-and-answer techniques, small-group exercises, role modeling, and repeated skills practice. These methods allow teachers to adjust program content to diverse classrooms with different levels of information and drug exposure.

Curricular materials include a teacher's manual with 14 detailed lesson plans (11 core plans and 3 booster lessons) two teacher demonstration videos, eight student videos, and classroom posters. Educators must enroll in a participative training workshop to receive the Project ALERT curriculum.

Risk Factors Addressed

Early First Use

Protective Factors Addressed

Skills

CSAP Strategy

Education

Type of Strategy

Universal

Populations Appropriate for This Best Practice

- Sixth and seventh grade students or seventh and eighth grade students
- Low-risk and high-risk students
- Minority students
- Various socioeconomic settings

Evaluating This Best Practice

This best practice comes with an evaluation tool that can be used when implementing this strategy.

Evaluation Tool Cost:
There is no cost for the evaluation tool.

The following are suggested areas to assess when implementing this practice:

- Assess the initiation rate of marijuana and tobacco use
- Assess the rate of tobacco use
- Assess the acquisition of refusal skills
- Assess the perception that "most people do drugs"

Research Conclusions

(Excerpt from "Research-Based Program Models" by the Center for Prevention Research and Development for *Illinois Prevention 2000*, July 1998, pp. 61-62.)

Evaluation reports conclude that Project ALERT achieves the following:

- Reduces the initiation of marijuana and tobacco use by 30 percent
- Reduces heavy smoking among experimenters by 50-60 percent
- Is effective for both high- and low-risk students, including minorities
- Performs equally well in a variety of socioeconomic settings

Costs as of December 2001 (Subject to Change)

Training Time: Seven hours

Training Cost: $125 per person

The training cost includes all curriculum materials. Once an educator is trained, he / she will receive print / video updates free of charge. Technical assistance regarding program implementation is also available to all trained educators and is included in the training fee.

Note: Training is required for all educators intending to implement the curriculum.

Special Considerations:
Please consider the following before selecting this strategy for your community:

- Project ALERT is specifically designed for middle school students (6-8 graders) and is best implemented in a regular classroom setting.
- Project ALERT training / curriculum, due to grant restrictions, is not available to after school programs or community organizations unless they are directly involved with a district's Safe and Drug Free School plan.

Contact Information

For more information on this program, visit web site:
http://www.projectalert.best.org and
http://modelprograms.samhsa.gov

For training, technical assistance to trained teachers, and materials contact:

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Additional references:

Ellickson, P.L., and Bell, R.M. (1990). Drug prevention in junior high: A multi-site longitudinal test. *Science*, 247:1265-1372.

Ellickson, P.L., Bell, R.M. & McGuigan, K. (1993). Preventing adolescent drug use: Long-term results of a junior high program. *American Journal of Public Health*, 83:856-861.